HOSPITALS

The Principles of Third-Party Payments
—A progress report

A New Standard for Oxygen Piping Systems
—Roy Hudenburg

Federal Regulations for New Construction
—Bremen I. Johnson

A Year-Old Modern Rural Hospital Reports
—M. B. Shroyer

JULY • 1951

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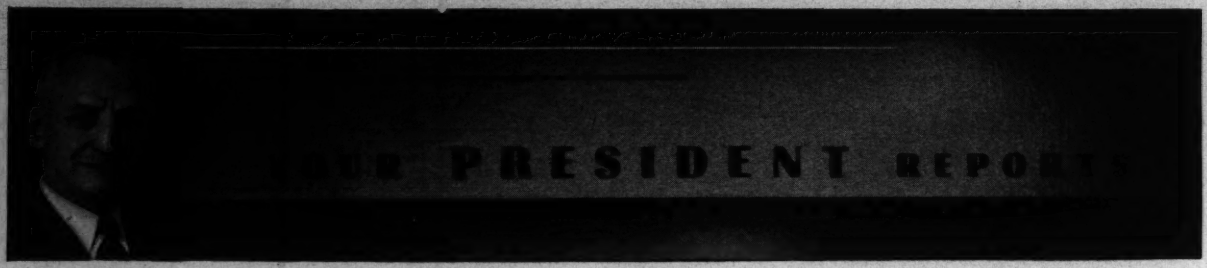
1. Goldenberg, Marcel; Apgar, Virginia; Deterling, Ralph; and Pines, K. L.: *J. A. M. A.*, 146:776, July 2, 1949.

L.C.



THE ACTIVITIES during the past month, while extremely varying, were typical of the many demands upon the officers of the Association. An invitation was received from Millard Caldwell, the government's top-level responsible officer for national civilian defense, to send delegates of the American Hospital Association to a planned conference on civilian defense scheduled for Washington on May 7 and 8. George Bugbee, Dr. Ed Crosby, John Hayes and I were your representatives at the conference attended by more than 1,000 delegates from all sections of the United States and its territories. Every phase of interest involved in civilian defense was presented. Luncheon and dinner sessions were attended by capacity audiences and addressed by leaders in American life. In addition to the prominent speakers at the luncheon session, the distinguished group who addressed us in the evening included the President of the United States, Vice-President Alben W. Barkley, Speaker of the House Sam Rayburn, House Majority Leader John McCormack and Secretary of Labor Maurice J. Tobin. Governor Caldwell, presiding at both sessions, emphasized the important part that must be played by civilians on the local and state level if an adequate program of civilian defense is to be developed and maintained.

A MEETING of representatives of the Inter-Association Committee on Health was held in Washington during the civilian defense conference, at which time plans were made for a previously arranged conference with Dr. Howard Rusk's Health Resources Advisory Committee of the Office of Defense Mobilization. It was agreed that one representative of each of our six agencies was to constitute the committee and that this representative would present the problems and needs of his organization as related to the total needs of the people. The members of our Association may be assured that John Hayes, who was our representative, presented ably and well a picture of our problems and needs. He stressed the desire of the American Hospital Association to cooperate with the Rusk Committee and emphasized the needs of hospitals in the present situation. In turn, the Rusk Committee promised every possible cooperative effort to help us and keep us informed.

DURING THE month, your president, as chairman of the Council on Governmental Relations of the Massachusetts Hospital Association, appeared with other hospital representatives before the Committee on Ways and Means of our state legislature and pleaded for larger and more satisfactory reimbursement than the present $10 per diem paid for the care of welfare cases. This session was well-attended by many representatives of our hospitals, who painted the picture of higher costs and larger deficits and stressed their belief in the responsibility of tax funds for reimbursement to hospitals for the care of the indigent. An able case was presented, and while no decision has yet been rendered we believe something will be done in the way of an increased rate of payment for the hospital care of recipients of public welfare.

READERS of this column will be interested, I am sure, in the attitude of students in courses of hos-

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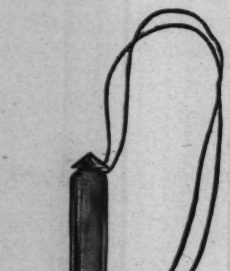

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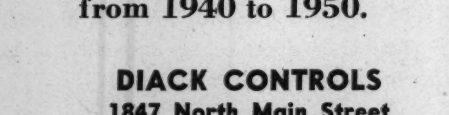

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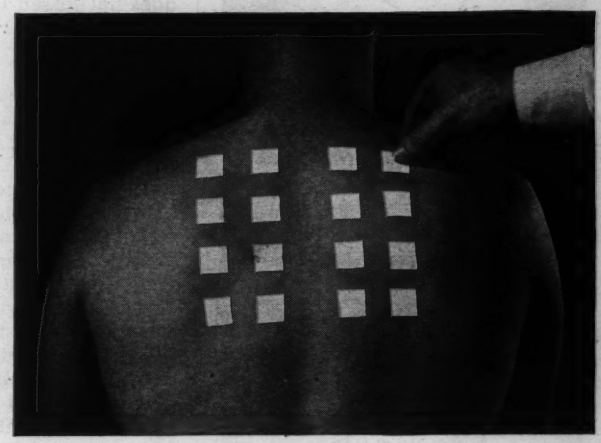
Since that time we have maintained a continuing program of clinical research on this subject. In all cases, the findings have corroborated that reported above.

The most recent of these studies was conducted by a consulting biochemist of very substantial reputation, who was commissioned by Bauer & Black to investigate the incidence and degree of skin irritation and allergy caused by adhesive. This clinical study was made with *Curity* Adhesive and with two other leading brands. In making the analysis, a substantial sample was used, and a very careful system of checks and controls was employed to assure a thoroughly unbiased, complete and objective report.

A summary of the findings has now been compiled. It verifies a fact borne out by earlier studies: viz., that *Curity* Adhesive is measurably less irritating than the other brands tested.



Copies of the findings, in digest form, are available to any member of the medical profession on request.

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pital administration reflecting not only an increasing interest in this field but also a quest for knowledge in hospital economics. I lectured recently to one of these groups at the Harvard School of Public Health, confining myself in substance to the need of the application of business principles in hospital management. I made a point that the carrying out of this practice did not need to impinge upon the field of satisfactory professional practice. I further emphasized that there is a greater need than ever (in view of present costs and with the unrest which this creates in the minds of the public, boards of hospitals, as well as hospital administrators) for the practice of sound economy, making sure nevertheless that this does not lessen the quality of hospital service.

It was a pleasure to serve as your representative at the third annual meeting of the Middle Atlantic Hospital Assembly, in Atlantic City, and to address the group under the title "The AHA Reports." This afforded an opportunity to inform the audience of the efforts and interests of the Association during the past year, which include the present status of our accreditation plan, wage and price stabilization, the Hill-Burton Act, as well as the continuing invaluable efforts of our executives, staff council organizations, and committees. I was delighted also to address a luncheon meeting of the women's auxiliaries of the New Jersey State Hospital Association. The interest of this group was stimulating indeed, and I availed myself of the opportunity to stress the important part which the women of this country are already playing in the life of our American hospitals. No one can prove more valuable in correcting misinterpretations and in selling the virtues of our hospitals to the community than the good women of America.

I availed myself of the invitation to present the greetings of the American Hospital Association to the members of the Hospital Association of New York State and to participate in a small measure in the session devoted to the future of nursing education. This was an interesting session, which included in its panel of discussants eight speakers, including Lucile Petry, Assistant Surgeon General and chief of the Division of Nursing of the Public Health Service. She delivered a progress report of the Advisory Committee on Nursing Education of the State University of New York. Many phases of nursing education were presented, and emphasis was placed upon the importance of the practical nurse as one of the solutions of the nursing shortage.

I would be very ungrateful indeed if I failed to call attention to a delightful social hour which I attended in company with many prominent hospital people as guests of Mr. and Mrs. Robert Gloman, (he is president of the Middle Atlantic Hospital Assembly) and Alma Troxell, president of the Hospital Association of Pennsylvania.

An opportunity was afforded me a few days ago to address, in a consulting capacity, a group concerned with general needed expansion of a community hospital in an area of about 60,000 inhabitants. Assembled were the essential segments of the population, including the mayor and city council, the members of the board of the hospital and its professional staff. The problem of necessary funds for expansion was an important deterrent. My purpose was to convince the board and city fathers, and through them the community itself, of the important place of the community hospital as a citadel of health and as a standby institution ready to meet at all times any needed emergency, as well as to meet the necessary everyday important demands upon the hospital. While I agreed with the existence of the many demands upon our communities in the way of schools, parks, playgrounds and other expanding facilities, I emphasized the cardinal priority of health and medical care upon which everything else is so materially dependent. I was bold enough to refuse to accept a secondary place for hospitals in the proposed financing of community services to meet community needs, and my optimism was rewarded by what appeared to be the satisfactory reaction of the audience at the conclusion of my presentation.

Charles F. Wilinsky, M.D., President,
American Hospital Association

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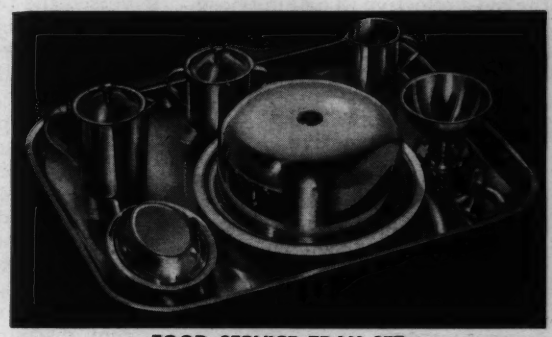

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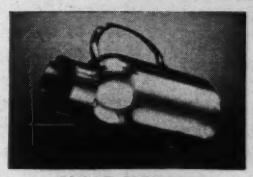

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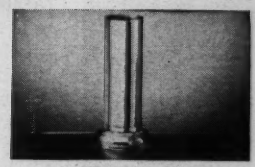

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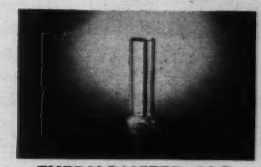

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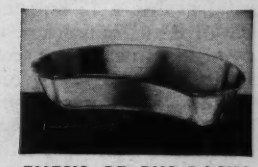

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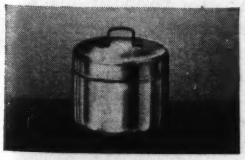

OINTMENT JAR

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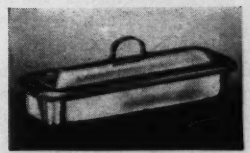

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BEDPAN

opinions

ON MAKING HOSPITAL JOBS ATTRACTIVE

HOSPITALS TODAY are faced with the problem of competing for labor under great handicaps. In most cases, because of inability to offer high salaries, hospitals must find other means of attracting workers. The four administrators below have found solutions and pass them on to readers as they answer the question: "When nonprofessional employees are hard to find and keep, what modern employment practices do you consider the most effective in making hospital jobs attractive—and will you compile a check list of six such items?"

Increased benefits make hospital job attractive

WHILE NO employment practices, regardless of their excellence, are proof against a turnover of hospital employees when the labor market is tight, nevertheless hospital jobs can be made attractive by emphasizing benefits which hospitals can adopt without too much strain on the budget.

DR. LITTAUER

At Menorah Hospital we have found the following inducements are considered important by our personnel:

1. *Hospitalization.* Hospital employees are enrolled in the Blue Cross plan. If an employee or a dependent is hospitalized, the hospital grants a 75 per cent discount on all items which are not covered by the Blue Cross contract and which normally are billed to the patient. If an employee is enrolled in a commercial insurance plan or if he does not carry Blue Cross, he receives a 75 per cent discount on the difference between the total bill and what Blue Cross would have paid for his hospitalization. With more than 300 employees, this discount in 1950 amounted to less than $4,000. It paid dividends many times over.

2. *Outpatient medical care.* Each employee is entitled to certain ambulatory services such as laboratory tests, x-rays and physical therapy treatments when ordered by his physician, the bill not to exceed $35 yearly. This benefit was instituted several years ago when it was found that friends of technicians were receiving services without charge. Since the practice is almost impossible to eliminate and since it always arouses resentment in other employees, we reversed the procedure to include all employees in the benefit. Few employees make use of the service or run up a bill of $35.

3. *Meals at cost.* The hospital operates a pay cafeteria in which meals are sold at the cost of the food and the labor involved in preparing it. Since visitors, members of the medical staff, occasional salesmen and others also may eat in this cafeteria, prices are raised above cost and meal ticket books are sold to employees at a 25 per cent discount. The profit derived from others than employees takes care of the overhead cost.

4. *Orientation.* An orientation program for new employees was instituted recently. This is conducted by the personnel department, which attempts to maintain a schedule of approximately once a week, for all new employees (excluding nurses) who have been hired during the previous week. Orientation consists of the following: Description of the various departments in the hospital and how they are interrelated; a question and answer session about employee benefits and problems new employees might wish to discuss, and a tour through the hospital floors.

5. *Lounges and locker rooms.* Inadequate locker rooms are being replaced by modern, clean locker rooms with toilets and showers, and rest areas containing easy chairs, ashstands and magazines. Each employee has an individual locker.

6. *Loan fund.* An employee loan fund has been set up for the benefit of workers who need cash in emergencies. This fund, which has been accumulated from money left over from employee dances or parties and from the sale of salvaged x-ray films and furniture, is controlled by a committee consisting of the personnel officer, a department head and two other workers. The committee passes on each request and the employee refunds the money in monthly or bimonthly payments without interest. In the 18 months this fund has existed, it has been used 13 times, and in most instances the money has been returned.

Other helpful practices are sick leave benefits, wage progression plans, and a house organ stressing employee news, parties and picnics.—DAVID LITTAUER, M.D., *director, Menorah Hospital, Kansas City, Mo.*

Clearly stated policies help new employees

SOME OF the things that may be done to increase the length of tenure and to obtain more satisfactory performance of nonprofessional employees are as follows:

1. Clearly stated personnel policies. These should be approved by the board of trustees and revised periodically to keep them up to date. They should be printed or duplicated and given to each employee when he starts to work. The name of the department to which he is assigned and the name of his immediate supervisor should be written on this sheet.

MISS SCHABINGER

2. A fair wage scale and opportunity for advancement within the organization are conducive to maintaining employees. In the small hospital especially, it is important to advance those already on the payroll to more remunerative positions if their backgrounds and abilities make it possible for them to perform the new duties. Scholarships may provide for extra training to fit the employee for a more responsible position.

3. The employee's induction to his job should be well planned and executed. At the time of his employment interview he must be told definitely where to report and at what hour. The person receiving him should see that he knows the location of the locker room, restrooms and the dining room and the relationship of his work area to the

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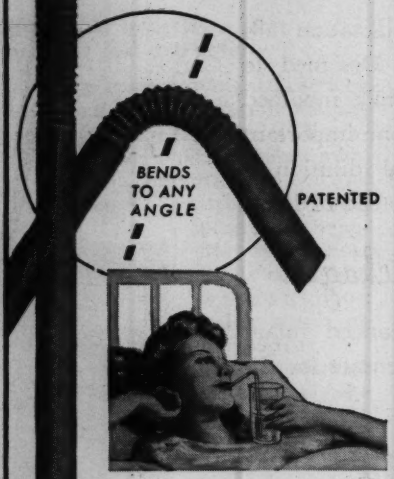

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rest of the institution. He should also be informed where to find his equipment and supplies.

4. Job analysis and work assignment sheets will simplify the task of the supervisor in his in-service training. The assignment sheet should be detailed enough to enable the employee to follow it with a minimum amount of checking up.

5. A rating system to allow the employee's work to be regularly graded. Information so derived will help the department head recognize an employee's ability and to work with him on weak points.

6. The employee must be able to derive job satisfaction from his work. Good performance should be recognized just as promptly as the failure to perform duties correctly. Public recognition of years of service may be made at an annual dinner.—MARY C. SCHABINGER, *superintendent, Detwiler Memorial Hospital, Wauseon, Ohio.*

Dignity of hospital work should be emphasized

THE PROBLEM of keeping nonprofessional employees has been met by us with more than reasonable success by:

1. Paying reasonable cash salaries, plus giving other considerations—the combined total of which equals a value that, generally speaking, is in alignment with national averages in nonprofit hospitals, even though this combined "value in kind" may not approach the general level being paid by industry in the community. When interviewing prospective employees, we always quote the cash figure, but we also quote in terms of dollars the reasonable value of the other considerations, which are the equivalent of cash. In this category are: A Blue Cross contract after the employee has been with us for six months; social security, vacations, sick leave benefits, uniforms and laundry.

MR. ALBERTI

2. Granting periodic cash increases, not on the basis of predetermined sums at stated intervals but on the basis of merit. Practically every payday, one or more persons in each department is given a salary increase in recognition of loyal and devoted service, and quite naturally this practice discourages employees from asking for salary increases. We find that the plan creates employee incentive, which would not be so obvious if we followed a plan of granting fixed or predetermined increases at specific times.

3. Repeated emphasis upon the permanency of employment at the hospital—in good and bad economic times—as compared to seasonal employment, (as, in our case, with the apple industry), even though the latter pays quite substantially during the season.

4. Exercising care in the employment of nonprofessional help in order to guard against "rolling stones" and job misfits. Here we always stress the fact that we do not want them unless they expect to be more than reasonably permanent.

5. Stressing the humanitarian phase of hospital employment. Incidentally, the impression this makes often is very interesting to observe, even where least expected.

6. Emphasizing the dignity of hospital work. I find that this frequently gives even a "lowly" worker somewhat the feeling of a white-collar employee.

The net result of the foregoing is that we have many nonprofessional employees who remain with us year after year and are not influenced by overtures from others or by seemingly greener pastures elsewhere.—H. E. ALBERTI, *administrator and treasurer, Winchester (Va.) Memorial Hospital.*

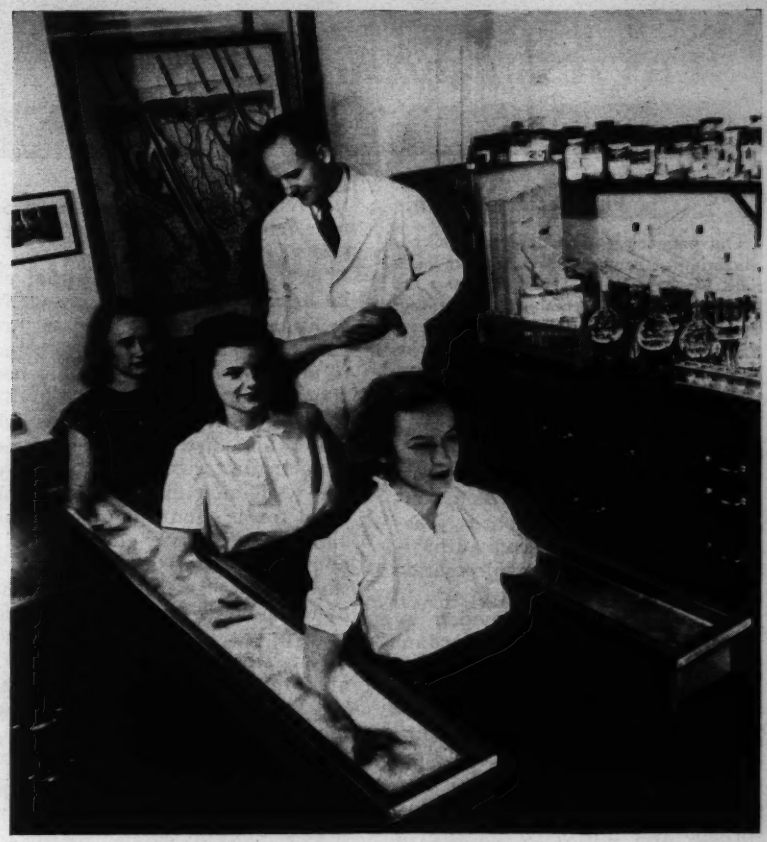
Administration must show interest in worker

PERSONNEL POLICIES which depict administration's concern for the best interest of each employee tend to build *esprit de corps,* serve as incentives for good performance, and keep the worker on the job.

Of importance to each employee are those tangible and intangible factors which give him heartfelt assurance that he is wanted and that his efforts are essential for operation of the hospital. His feeling of belonging is enhanced by such activities as timely recognition in the hospital bulletin, ready access to the suggestion box, regular attendance at meetings headed by his department chief, and occasional invitations to convocations at which the administrator speaks to employees.

Among the obvious factors which engender a sense of security and a feeling of achievement in the non-

(Continued on page 142)



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Our patient area corridors have ceilings consisting of combustible acoustical materials. We have been advised that, as a fire precaution, these combustible ceilings should be replaced—an extremely expensive operation which we will undertake, if necessary. We also have learned, however, that a fire resistive paint is available to protect these ceilings. Do you believe that coating with a fire resistive paint is a safe treatment?

When a combustible acoustical material is applied against a noncombustible ceiling, such as plaster, most fire prevention authorities agree that sufficient protection against the rapid spread of fire in the corridor can be provided by what are known as flame retardant paints. It should be noted that these paints gradually lose their protective qualities and, therefore, should be reapplied about every seventh year. It must be remembered that the paints protect only the painted surface against flame spread. The untreated back of a combustible material is still subject to rapid flame spread in concealed spaces.

Three brands of flame retardant paints have been approved for use in Army installations. Two of these are washable oil based paints. All are available in either an off white or a tinted color. For names of these brands, write the editorial department of HOSPITALS, 18 E. Division Street, Chicago 10. —ROY HUDENBURG.

Nurse recruitment aids

Our auxiliary is planning a tea for the purpose of recruiting nurses. How may we obtain the film "Girls in White" and nurse recruitment literature for use at that time?

The film "Girls in White" is available in 16 mm size and may be rented for $4 for three days, plus $1 for each additional day. Purchase price is $60. The film has been used effectively hundreds of times to interest young women in the nursing profession. It should prove helpful in your program.

Material for the 1951 nurse recruitment program is ready for distribution, and we still have available a public relations guide published in 1948. It was sent to all hospitals who are members of the Association. If you cannot obtain one, we can supply it at a cost of $1.

There are a few ideas that can be applied generally to nurse recruitment teas. Invite two or three attractive student nurses to attend in uniform. After the film has been shown, the guests might be invited to ask questions of the nurses, who would also distribute literature on a particular nursing school or on the profession in general. Enrollment forms should be made available in case some girls decide to apply for admission at once. Be sure to have each girl register her name and address at the tea so you may follow up with an invitation to tour the hospital and school of nursing. It is important, too, that the prospective students be given the name of a particular person at the school or hospital with whom they can discuss details of training. You could stress this point during the tea.

Recruitment material mentioned may be had by writing to Mrs. Muriel Henry, Secretary, Committee on Careers in Nursing, 2 Park Avenue, New York 16.— C. J. FOLEY.

Industrial soliciting

We are planning a fund-raising campaign for a new hospital wing and are wondering whether there is any established pattern for industrial employee donating. For example, when we approach the industries in our city, is there any accepted system of contributing they would recognize as being fair? Since many firms must be receiving requests for money almost constantly, it would seem that they would have a set amount to contribute for each employee. Can you give us any information on this subject?

Although we cannot recommend any specific methods of industrial employee solicitation, we are familiar with some techniques that have been used successfully. A plant in one large city asked its hourly-rated workers to contribute one day's pay to the hospital fund. As an inducement, the company agreed to make payroll deductions over a period of several months.

In some areas, those who are not hourly-rated have been asked to subscribe 1 per cent of their yearly salary for three years. This has frequently been a successful appeal.

It is my impression that some of the fund-raising organizations do have a formula. For example, in a community with one hospital, they would divide the total value of the hospital by the number of employed workers in the community and ask each industry to contribute on a per capita basis. In a multi-hospital community, the calculation is the same but related to the percentage of service given by the individual hospital.

Employee response, of course, depends entirely upon the company's acceptance of such a plan and requires vigorous company endorsement. The key to success obviously is to secure the company's own contribution first.

In some communities where the campaign goal has been relatively high, workers have contributed 12 hours' pay.—GEORGE BUGBEE.

Age of pediatric patients

What is the usual age range for patients admitted to the pediatric service of a hospital?

The age range for patients admitted to the pediatric service is usually 12 to 14 years and not more than the latter. Admission above this age should be a matter of individual or special consideration and would depend considerably on the characteristics of the patients as to habits, attitudes, psychological aspects and the like. — DR. MALCOLM T. MACEACHERN.

Emergency power plant

We should like to secure for our hospital a stand-by power plant for emergency use. Will the civil defense office supply it?

I know of no arrangement whereby the civil defense authorities can purchase this equipment for your hospital. The contemplated arrangement, as I understand it, is that in the event of a major catastrophe it will be the responsibility of civil defense authorities to lend a generator to hospitals deprived of electrical services and serving catastrophe victims.

It is the belief of the Council on Hospital Planning and Plant Operation that hospital equipment should include a stand-by source of electrical current for use when service by public utilities breaks down. Unfortunately, I know of no source of aid in financing the purchase of such equipment. — ROY HUDENBERG.

A SUCCESSFUL CONFERENCE

The principles of third-party payment for hospital care

SEVENTY MEN and women sat around a large improvised conference table in Chicago late in May, at the invitation of the American Hospital Association, and arrived at the nearest thing to agreement yet seen on the controversial problem of third-party payment for hospital care.

The agreement was not unanimous, nor was it on specific methods of determining and making payments. It was, instead a *general* recognition of *principles* of fair reimbursement to hospitals by third-party groups and agencies.

For many years, the economics of hospitalization concerned only two parties—the patient and the hospital. But in recent years, a large percentage of patient income has been reaching the hospital through such organizations and agencies as Blue Cross, local and federal government, welfare funds, and health societies and foundations. These have been collectively labeled third-parties, for, in a financial way, they insert themselves between the patient and the hospital.

The American Hospital Association, in calling the widely representative three-day conference, hoped to set the stage for elimination of the injustices that are bound to creep into the implementation of a rapidly growing concept.

WIDE VARIATIONS

Everyone concerned with third-party payments to hospitals is aware that the methods and amounts of these payments show large variations. In some instances, both the purchasers and the providers of group hospital care are satisfied with the systems they have worked out. In other instances there is dissatisfaction on one or both sides.

Some third parties pay costs, some pay a percentage of cost, some pay established rates. Some, particularly state and local governments, pay flat rates that are not easily adjustable to keep pace with the cost of hospital service.

The 70 persons who met in Chicago to discuss these problems represented the buyers and the sellers of group hospital care. The broad representation included hospitals and hospital organizations; local, state and federal governmental agencies; Blue Cross and other prepayment plans; labor health and welfare funds; national health societies and foundations, community welfare councils; and local nonprofit health and welfare organizations.

Under the leadership of Dr. A. W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn., the conferees explored possible answers to this question: For how much money and on what basis should hospitals sell their services to third-party purchasers of hospital care?

When the conference ended, the basic question remained unanswered, and this was as anticipated. But a great deal of progress had been made, for the conference enabled the large-quantity buyers of hospital care to get together with those who sell it and to discuss (not negotiate) their areas of agreement and disagreement.

ENCOURAGING AGREEMENT

The amount of agreement was encouraging to most. It was a definite indication of progress toward the conference's goal—to arrive at reasonable conclusions, not something final and binding upon either the purchasers or providers of hospital care.

The subject is both broad and deep, and those at the conference felt that when the meetings ended they were just getting started in the task of pulling out the issues and turning them into something positive. For that reason, tentative plans call for a second meeting, to be held later in the year. This second meeting is to be smaller than the first and will attempt to prepare a fair and realistic set of principles for submission to hospitals and the purchasing agencies concerned.

In the meantime, a preliminary summary of the first conference will be sent to state hospital associations for review and suggestions.

The document that will finally emerge from these conferences will not constitute any official pronouncement of policy. Throughout the conference, the authority and responsibility of third-party agencies and hospital governing boards were jealously protected. What is hoped for is a body of information and philosophy, drawn from the experiences and ideas of those who

buy and sell hospital care, that might be used by local groups as the basis for their policy discussions. There will be no nation-wide collective bargaining or negotiating as a result of these meetings.

THE TREND OF THINKING

Here are some of the subjects that were discussed:

Costs: Most delegates felt that agencies purchasing hospital care should pay the "full cost" incurred in providing the services authorized under their agreements with hospitals. "Full cost" was not defined, however, and this is a job that must be done before complete agreement is possible.

Obligations: When hospitals are paid this "full cost," the group agreed generally, these institutions must accept the obligation of providing proper facilities and good service—at the same time considering economy and efficiency of operation. Some of these obligations might include:

1. The responsibility to provide adequate facilities and a broad and comprehensive level of up-to-date service.

2. The responsibility to study individually and jointly, better administrative and professional practices, so that the best service may be provided at the lowest cost to nonprofit and governmental purchasers.

3. Development of criteria and methods by which hospitals can be reviewed by their own organizations as to quality, scope and efficiency of service, so that payments made by individuals and third parties might reflect the services rendered at the lowest possible cost.

4. The responsibility of making available, upon request of group nonprofit and government purchasers of hospital care, fiscal and administrative information necessary for a continuing agreement on amount of payment and services provided.

5. The use of uniform and accurate accounting methods.

6. Submission to third-party purchasers of a statement of operating costs, prepared in accordance with agreed cost formulas, this statement to be certified when requested by the third party.

7. The responsibility to cooperate with nonprofit and governmental buyers of hospital care in studying those factors that effect cost of services to agencies purchasing care, including admission, length of stay, extent and amount of services provided, with a view to efficient use of funds.

Standards of service: The group was in general agreement that the amount and method of payment to hospitals should stimulate continuing development of a broader scope and higher standards of service, as well as safeguarding present standards of care.

Comparative charges: There was considerable discussion of variations between established rates to individual patients and the amount some hospitals charge third-party purchasers for similar care. The group agreed in principle that the practical application of third party payments of the "full cost" of providing services would be expedited if these established rates to individual patients, for similar services and accommodations, are not less than those paid by third-party agencies.

Rates of payment: Nearly everyone agreed that rates of payment should reflect current hospital costs and that payments to individual hospitals for the same unit of service might differ.

Cost formula: The group indicated a willingness to accept the principle of payment of "full cost" as embodied in the Government Reimbursable Cost Formula, with several qualifications. For example, the delegates felt that expenditures clearly identifiable as being made for research purposes, over and above usual patient care, should not be included in determining cost of patient care.

Education: There was disagreement on the question of including the cost of undergraduate education in hospital service costs. Nor did the group unanimously favor exclusion of bad debts, charity and courtesy allowances as proper items of expense.

Remodeling: Generally the conferees agreed that ordinary remodeling is a charge against maintenance and repairs and hence should be included in expenses, but extensive remodeling should be capitalized and therefore not included as an operating expense.

Interest: A few hospital representatives and several third party delegates objected to the principle that interest costs on capital indebtedness should be included as an operating expense item. The majority on both sides nevertheless felt that this principle was sound.

Services of nuns: With a few negative or indecisive votes from the third-party purchasers, the group felt generally that it is legitimate to recognize as operating expenses the reasonable value of the services of sisters or members of other religious orders who serve fulltime or part-time in hospitals.

Emergency personnel: During the conference, some third-party representatives reported that hospitals sometimes include as an expense the cost of extra or specialized employees whose salaries are paid by government or foundations. It was generally agreed that under such circumstances the hospital should deduct from expenses the income used to cover the cost of such furnished employees. As an example, when the National Foundation for Infantile Paralysis provides a hospital with funds to hire an extra nurse or a physical therapist during a poliomyelitis outbreak, the hospital is not expected to charge the foundation again for the services of that person.

Newborn: Most delegates felt that the hospital reimbursable cost formula should provide for a separate cost for newborn nursery care.

Depreciation: The discussion of depreciation was accompanied by very little unanimity. The consensus was that depreciation should be included in per diem costs, but a sizable number of delegates expressed negative or indecisive opinions. A few delegates favored the principle that depreciation should be included in per diem costs only if it is funded by the hospital.

Endowments: Most agreed that hospitals should not be required to use endowment funds or gifts to reduce third-party payments. It was argued that such gifts and endowments were not intended to lower the charges to patients whose care is paid for by third-party purchasers.

Third-party payments—these are the questions

When the American Hospital Association called its conference on method and amount of hospital payment, the delegates were after answers to these questions, which indicate the scope of the problem:

EQUITABLE AMOUNTS OF PAYMENT

1. What criteria or justification of amounts of payment can be suggested which will permit their acceptance by the hospital and their payment by the purchasing agency?
2. Should the amount of payment reflect quality of care?
3. Should the amount of payment by purchasing agencies be the same or different than amounts paid by individual self-paid patients?
4. Under what circumstances are public agencies justified in paying hospitals more than their regular established rates?
5. Under what circumstances are hospitals justified in accepting from public agencies lesser amounts than the hospitals regular established rates?
6. Should amount of payment for similar services in an individual hospital be uniform for all purchasing agencies?
7. Are there elements of stand-by services, such as those related to preparedness to meet disaster situations under civilian defense planning which should not be financed by revenue from patient services?
8. Are there conditions and methods by which the amount of payment by a purchasing agency can be utilized as an inducement to hospitals for improvement of their facilities and services?
9. Should earnings from services rendered to inpatients and ambulatory patients bear a specific relationship to the operating expense of the hospital?
10. Should the amount of payment for inpatient care be related only to the direct expenses for providing services to inpatients?
11. Are costs related to educational programs, research projects and outpatient services considered legitimate charges against purchasing agencies for services provided to their in-bed patients?
12. On what basis should amounts of payment be determined for special services, such as x-ray, laboratory, physical therapy, etc., rendered to ambulatory patients who are referred to hospitals for these services?
13. What principles should determine the amount to be paid for services rendered to ambulatory patients in outpatient departments and clinics?
14. Is it reasonable for a purchasing agency to underwrite all or a major portion of a special service for a particular group of patients for which that agency assumes special responsibility? (Cancer, polio, heart disease, maternity care).
15. Should the amount of payment for maternity care reflect costs of services to the infant during the stay of the mother?
16. Should the amount of payment by any agency be uniform to all hospitals in (1) a city, (2) an area, (3) a state, (4) the nation?
17. Should the amount of payment to a hospital be an average rate (1) for all patients in that hospital, (2) for special categories of patients, (3) for some other classification of patients?
18. What should be the relationship between the amount paid for care and (1) cost of such care, or (2) regular charges for such care?

METHOD OF PAYMENT

1. Should the same principles governing method of payment be applicable to all agencies which purchase care?
2. From the standpoint of assuring the provision of needed services to the patient and of facilitating administrative procedures of both hospitals and purchasing agencies, what unit of service (1) patient days (2) bed days (3) special services (4) other, is considered the most satisfactory basis upon which the method of payment should be built?
3. What should be the basis of method of computing amounts of payment to hospitals (1) cost (2) charges (3) other?
4. Should the method of computation of payment include considerations of (1) type of accommodations (2) type of case (3) length of stay?
5. What method should be employed to recognize cost of infant care in maternity cases, special services to complex orthopedic and other "high cost" cases?
6. Should the method of computing amounts of payment by purchasing agencies include a factor for standby costs (availability)—that is, should "bed-day" costs be reflected in patient day payments?
7. Is it sound policy to include in the method of computing amount of payment allowances for the cost of maintaining hospital units not fully utilized at all times (such as convalescent facilities, premature nursery units and polio patient facilities) and should such allowances be absorbed in rates of payments made for care of all other patients?
8. What authority should be established for authorizing payment of mutually acceptable amounts?
9. How frequent should payment for services rendered be made to hospitals by purchasing agencies?
10. What arrangements should be made by purchasing agencies to finance current operating expenses during interim periods between the times services are rendered and final settlement is made?
11. What administrative principles should be adopted by purchasing agencies to insure their prompt acceptance of liability and payment for care?

CONTROL OF AMOUNT OF PAYMENT

1. Should a payment formula serve as a basis for detailing a hospital's expenses in providing the services rendered?
2. What criteria (or expenses) would be legitimate for inclusion in such a payment formula?
3. Does the government reimbursable cost formula provide basic criteria for controlling the amount of payment?
4. Should a purchasing agency pay amounts that provide for increasing capital assets through improvement or replacement of facilities?
5. Should a purchasing agency have the right to audit hospital records for verifying data submitted to the agency by the hospital?
6. What factors may serve to protect the purchasing agency against excessive rates of payment because of (1) inefficient hospital operation, (2) inefficient hospital plant, (3) hospital operations that provide more than basic services, such as luxury accommodations or luxury standards of service?
7. Would the application of maximum rates applied by purchasing agencies be an acceptable method of controlling maximum amount of payment?
8. Is a limitation on variations of costs between hospitals an acceptable control factor?
9. Should some service criteria such as nursing hours per patient be established as limiting factors?
10. Should differentials in wages and cost of living indices serve as determining factors for controlling differences in amounts of payment in various sections of the country?
11. Should the degree of utilization of a hospital be a controlling factor in the amount of payment and if so, on what basis should rate of occupancy be applied?
12. Should hospitals be "rated" according to scope and quality of services as a method of controlling amounts of payment?
13. What principles or factors may be adopted by a purchasing agency to measure and to evaluate the scope and quality of services rendered in relation to the amount of payment for care?
14. What principles shall control amounts of payment by one agency when beneficiaries of that agency also utilize hospital service benefits under an insurance program or another agency?

A NEW STANDARD for nonflammable medical gas systems

ROY HUDENBURG

FILLING the vital need for a standard to control the piping of oxygen, the National Fire Protection Association recently adopted and released its "Standard for Nonflammable Medical Gas Systems."

Development of this standard comes at a time when the therapeutic use of oxygen has markedly increased and when oxygen piping systems are being installed in hospitals at a rapid rate. The Administrator's Guide Issue, Part II of HOSPITALS for June 1951, contains a table showing that 507 hospitals now are equipped with oxygen piping systems. Of these, 230 hospitals pipe oxygen to the patient rooms.

APPLY TO ALL HOSPITALS

That these systems are not confined to large hospitals is indicated by the fact that 50 hospitals of fewer than 50 beds have oxygen piping systems supplying patient rooms. Ninety-six hospitals with fewer than 100 beds supply oxygen to their operating rooms and 92 supply oxygen to the patient rooms by means of piping. The safety requirements have been put into a form readily accessible to architects and mechanical engineers who are now designing oxygen piping systems.

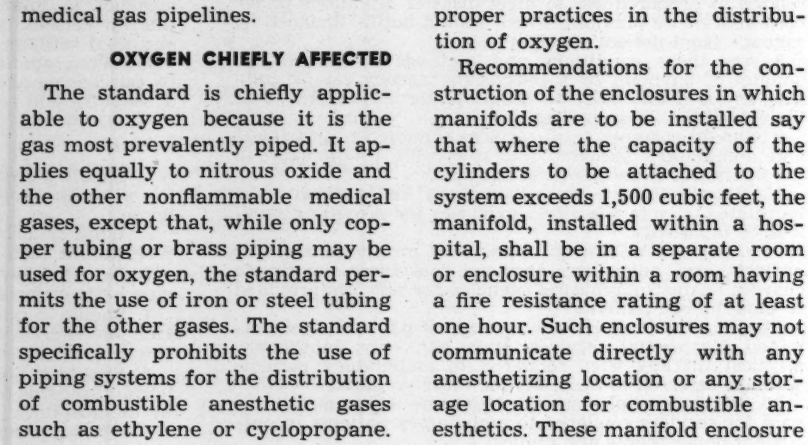
Previously, safety was assured by the engineering provided by the oxygen suppliers who had devised standard procedures in keeping with the hazards involved. While this type of engineering service is still being provided, an increasing number of installations are being designed by independent mechanical engineers who do not have experience in the handling of medical gas pipelines.

OXYGEN CHIEFLY AFFECTED

The standard is chiefly applicable to oxygen because it is the gas most prevalently piped. It applies equally to nitrous oxide and the other nonflammable medical gases, except that, while only copper tubing or brass piping may be used for oxygen, the standard permits the use of iron or steel tubing for the other gases. The standard specifically prohibits the use of piping systems for the distribution of combustible anesthetic gases such as ethylene or cyclopropane.

The standard provides specifications for the construction of the manifolds to which oxygen cylinders are attached as a source of supply. It recommends that such manifolds be obtained from and installed under the supervision of manufacturers familiar with the proper practices in the distribution of oxygen.

Recommendations for the construction of the enclosures in which manifolds are to be installed say that where the capacity of the cylinders to be attached to the system exceeds 1,500 cubic feet, the manifold, installed within a hospital, shall be in a separate room or enclosure within a room having a fire resistance rating of at least one hour. Such enclosures may not communicate directly with any anesthetizing location or any storage location for combustible anesthetics. These manifold enclosure



LOCATION OF VALVES IN PIPING SYSTEMS FOR OXYGEN OR NITROUS OXIDE (Schematic)

Courtesy National Fire Protection Association

SHUTOFF valves shall not be installed in the main oxygen supply line. Certain risers will have a shutoff valve immediately adjacent to the junction with the main supply line.

Mr. Hudenburg is secretary of the Council on Hospital Planning and Plant Operation of the American Hospital Association and of the N.F.P.A. Committee on Hospital Operating Rooms.

At a time when the therapeutic use of oxygen has greatly increased, the National Fire Protection Association has filled a vital need by releasing a new standard on piping all nonflammable medical gas systems in hospitals.

areas are required to have outside ventilation.

The standard also prohibits the storage of any materials in the manifold room, permitting storage of only spare cylinders for the nonflammable gases intended to be distributed through the system.

PIPING SPECIFICATIONS

Under pipeline recommendations, it is specified that Type K and Type B copper tubings are to be used for oxygen piping. For exposed locations, a hard tempered tubing is required, whereas soft tempered tubing is recommended for underground and concealed pipe locations.

The piping may be buried underground if it is adequately protected against frost, corrosion and physical damage. Such protection against physical damage contemplates the use of protective ducts or casings. The standard permits the placing of oxygen piping in well ventilated tunnels together with fuel gas pipelines but prohibits this procedure where the oxygen pipe may be exposed to contact with oil.

It is specified that the opening through which pipelines run in concealed spaces shall be firestopped. The use of pipe shafts for oxygen risers is permitted if suitable protection is provided against physical damage, excessive heat, and contact with oil.

IDENTIFYING PIPELINES

Particularly important as a change in procedures is the recommended method of identifying pipelines. Color coding of pipelines is acceptable only as a supplementary means of identification. The standard requires that pipelines be identified by appropriate labeling (metal tags, stenciling, stamping or adhesive markers) with the name of the gas contained.

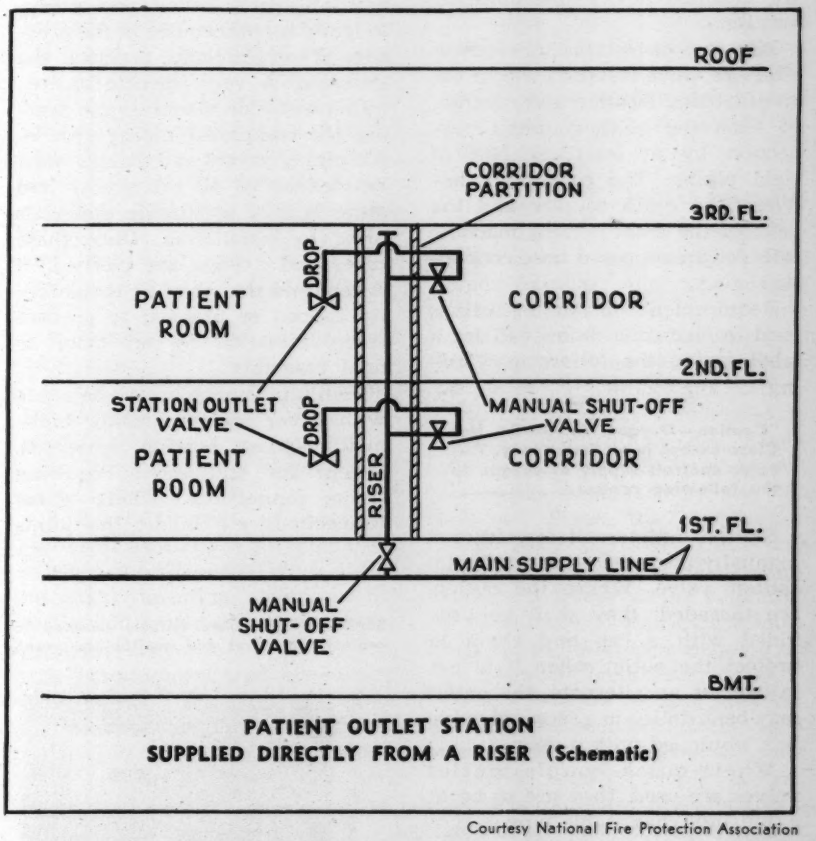
The standard prohibits the installation of a shutoff valve in the main oxygen supply line. It provides that each riser leaving the main supply line shall be equipped with a shutoff valve immediately adjacent to the junction with the main supply line.

MANUAL SHUTOFF VALVES

When patient outlet stations are supplied directly from a riser, it is required that a manual shutoff valve be installed in the same floor and between the riser and the outlet, with a corridor partition intervening. In other words, in connecting a riser directly to a consumption outlet, the connecting line must run to a corridor partition, where the shutoff valve must be installed, before connecting with the outlet. This hookup is distinguished from the lateral branch which is valved at its junction with the riser before proceeding to supply one or more outlets. Schematic piping illustrations are included in the standard to indicate visually these valve locations (see illustrations).

This specified provision of valves has been worked out so that patient outlets will be controlled by a manual shutoff on each floor of the hospital. It should not be interpreted that there shall be a corridor valve for each patient room, except when the patient room is fed directly from a riser. Valves on lateral feeder lines must be arranged so that shutting off the supply of gas to any one branch will not affect the supply of gas to the remainder of the system.

The requirements for shutoff valves for supplies to anesthetizing locations are covered under separate requirements. These call for a manual shutoff valve outside of each anesthetizing location, so situated that it is readily accessible for use in an emergency. The



PATIENT OUTLET STATION SUPPLIED DIRECTLY FROM A RISER (Schematic)

Courtesy National Fire Protection Association

PATIENT outlet stations shall not be supplied directly from a riser unless a manual shutoff valve is installed between riser and outlet with a corridor partition intervening.

valves are required to be of an approved type and so installed as to be protected against physical damage. The location is to be marked to prohibit tampering or inadvertent closing with a warning such as "Oxygen—Do Not Close."

Valve location boxes are now being made with glazed doors, for mounting within a wall where piping is concealed, as in new construction, and for mounting on the outside of a wall, where piping is run in the open, as in the case of existing buildings piped after construction. The boxes come labeled with appropriate warnings against closing except in the event of an emergency.

Valve arrangement is required to be such that the shutting off of the supply of gas to any one anesthetizing location will not affect the supply to other anesthetizing locations. The requirement for the manual shutoff valve immediately outside the anesthetizing location is not mandatory when non-interchangeable, quick-coupler outlets are installed in the anesthetizing location.

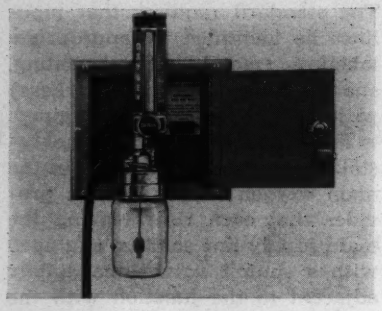
This type of installation requires a service valve installed within the anesthetizing location and separated from the quick-coupling connection by at least six feet of rigid piping. The connection between the quick-coupler and the yoke of the anesthetizing machine calls for an approved hose connection.

Requirements for shutoff valves used in operating rooms call for a label giving the following wording:

"Caution—Oxygen Valve—Do Not Close Except in an Emergency. This valve controls supply of oxygen to the following rooms:....."

Station outlets call for either a manually operated or an automatic shutoff valve. Where the outlets are threaded, they shall be provided with a cap and chain to protect the outlet when it is not in use. As an alternate, the outlet may be installed in a recessed valve box, equipped with a door.

Where quick-coupler outlet valves are used, they are to be of a non-interchangeable type so that equipment not intended for use in oxygen service cannot be applied



SHUTOFF valves, outside anesthetizing locations, will be accessible in emergencies.

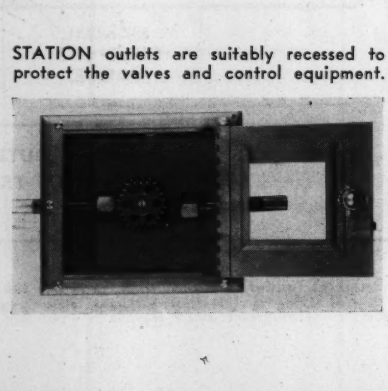
or connected to an oxygen outlet. These quick-coupler valves must be provided with an automatic shutoff valve incorporated in such a manner that the quick-coupler may be removed without operating the branch line shutoff.

Station outlets in patient rooms must be approximately five feet above the floor or else suitably recessed. This requirement is to prevent mechanical injury to the valve and control equipment.

Because of the widely recognized property of oil and grease to ignite spontaneously in the presence of oxygen under pressure, the standard is very specific on requirements for cleaning and testing the completed piping system. All piping valves and fittings must be cleaned of all oil, grease and other readily oxidizable materials prior to installation. Once these pipes and fittings are cleaned, it is required that they be temporarily capped or plugged to prevent recontamination by oil prior to final assembly.

Joints in piping are to be made with silver solder or other high-melting-point brazing materials, except for equipment requiring screw connections. Where screw connections are made, the joints

STATION outlets are suitably recessed to protect the valves and control equipment.



are to be made by tinning the male thread with soft solder. The foregoing points are among the major requirements of the standard. Reference to the actual standard is necessary for checking minor details.

The pamphlet, known as N.F.P.A. Standard No. 565, is available on request. Single copy requests will be filled without charge.*

COMMITTEE MEMBERS

The standard was developed by the N.F.P.A. Committee on Hospital Operating Rooms with advice from the Compressed Gas Association. George H. Buck of the University Hospital of Baltimore, is chairman of the Hospital Operating Rooms Committee. The secretary of the American Hospital Association's Council on Hospital Planning and Plant Operation is also secretary of the operating rooms committee.

Other hospital representatives on the committee include Dr. Jacob J. Golub, of the Hospital for Joint Diseases, New York City; Harriet L. Aberg of Galesburg (Ill.) Cottage Hospital, representing the American Association of Nurse Anesthetists; Dr. Ralph M. Tovell of Hartford (Conn.) Hospital, representing the American Society of Anesthesiologists; and Dr. Carl W. Walter of the Peter Bent Brigham Hospital of Boston, representing the American College of Surgeons. The standard replaces an obsolete recommendation of the National Fire Protection Association developed in 1934.

Concurrent with the adoption of this standard, the N.F.P.A. revised its recommendations for hospital operating rooms to secure consistency between the new standard and provisions for the piping of gases to anesthetizing locations as set forth in the operating room standard. Physical requirements for gas cylinder storage rooms also were revised to conform with the new standard. In a clarifying amendment, areas in surgical suites intended for the storage of combustible gases were specified as the only storage area requiring conductive floors.

*Address requests to Editorial Department, HOSPITALS, 18 E. Division Street, Chicago 10.

A year-old modern rural hospital reports

M. B. SHROYER

At Crossville, Tenn., we have what is perhaps one of the nation's best examples of a modern hospital of its size and type with regard to medical staff organization, personnel staffing, equipment and laboratories.

The Cumberland Medical Center was made possible by federal and state funds appropriated under the Hill-Burton Hospital Survey and Construction Act, together with funds raised through local participation and effort. It owes its existence to a determined band of Crossville and Cumberland County business and professional people who, beginning in 1946, worked unselfishly and against opposition for nearly two years before their concerted efforts succeeded in securing this sorely needed modern hospital for Crossville and its rural area.

Crossville's new general hospital has a normal complement of 50 adult beds and 12 bassinets. It represents an initial investment of $707,900 for land, building and equipment. The federal government's share of the cost amounted to $235,800; state aid provided $227,400, and local investment was $244,700.

From Jan. 1, 1950, to March 15, 1950, when the building was in the final stage of construction, the operational organization of the hospital was accomplished. This included:

1. Organization of the board of directors, establishment of its governing by-laws and the appointment of an administrator.

2. Organization of the active medical staff, establishment of its governing by-laws and appointment of a chief of staff and medical board by the board of directors.

3. Organization of a consulting staff of qualified medical and surgical specialists in the fields of urology, pediatrics, thoracic surgery, general surgery, internal medicine, radiology, pathology, obstetrics and gynecology, orthopedic surgery, eye, ear, nose and throat, neurological surgery, and anesthesiology.

4. Establishment of hospital service rates.

5. Establishment of personnel job classifications and wage and salary schedules.

6. Establishment of hospital personnel policies.

7. Establishment of hospital rules and regulations governing the conduct of professional work in the hospital, including definition of major and minor surgery and surgical privileges.

8. Procurement and placement of movable equipment and furnishings costing $93,000, and purchase of expendable operating supplies costing $11,000. (Fixed equipment valued at $42,000 was installed during construction.)

9. Procurement and organization of a complete staff of technical and service personnel.

On March 19, 1950, the Cumberland Medical Center opened its doors for occupancy. Four patients, one obstetrical, one medical, and two surgical, were received on opening day. At first there was noticeable skepticism, a tongue-in-cheek attitude regarding the new institution. One got the impression that it was looked upon as a place to go for treatment only when the patient was at death's door, instead of a place to go for speedy recovery.

INITIAL PROBLEMS

Our hospital in this small but progressive town has presented some unusual and challenging problems. It is a new hospital in a town where an institution of its kind did not exist before, and the people of the Cumberland County area, having been accustomed to medical treatment in their homes and in doctors' offices, were not too easily persuaded to use the hospital. Since the people are rather poor and since there was very little hospital and medical insurance coverage at the beginning of operations, it was all the more difficult to develop utilization of the hospital's facilities.

There was no medical staff organization; specialists in the various branches of medicine were not available locally; people favored hospitals in distant cities for treatment of the more serious illnesses; and, as is not unusual in an under-

Mr. Shroyer was formerly administrator of Cumberland Medical Center, Crossville, Tenn.

Operating statistics, March 1950 to January 1951, inclusive

Cumberland Medical Center, Crossville, Tenn.

1950	Admissions	Patient days of care*	Highest census	Lowest census	Average stay	Daily average census	Number of newborn	Major operations	Minor operations	General anesthesias	Lab. exams	X-rays	% of occupancy	Cost per patient day	Earnings per patient day
March	23	103	14	2	3.1	8	4	6	8	9	310	5	6.8	73.54	19.83
April	68	363	20	8	5.4	12.4	4	25	9	29	506	65	24.2	31.43	17.63
May	74	251	17	5	4.2	8.2	7	18	22	33	457	96	16	46.25	19.88
June	113	515	25	13	4.2	17.1	16	26	40	59	795	53	34	23.34	17.08
July	103	445	22	6	4.2	14.3	16	24	39	47	682	53	30	28.11	17.03
August	75	499	22	14	5.3	16.1	12	15	8	32	627	63	33	23.64	15.19
September	110	506	27	10	6.4	16.8	15	36	18	52	774	83	34	22.97	16.85
October	76	383	20	5	4.7	12.1	8	8	13	26	636	103	26	32.72	19.12
November	89	477	21	11	5.3	15.9	11	16	33	41	874	90	31.8	24.11	17.55
December	92	572	28	13	6.0	18.4	9	15	23	33	941	95	38.2	20.91	17.39
1951															
January	122	805	39	16	6.9	26.0	15	19	23	33	1206	141	54	16.71	16.14

Newborn days converted—Three equal one adult day

taking of this kind, there were several influential persons who, mainly because of financial considerations, were at first opposed to the idea of a new hospital.

After 10 months of operation these problems were overcome or at least no longer existed as such. The hospital's services have been rigidly developed and maintained along lines that we think should amply qualify the institution for American College of Surgeons' approval.

PUBLIC RELATIONS

By means of a never-ceasing educational program carried on through the press, the theaters, civic organizations, special hospital tours, nurse aide training courses, the county medical society and other groups, a universal pride in the hospital seems to have replaced the skepticism.

Vigorous and continuing effort to promote enrollment in the various hospital and medical insurance plans, notably Blue Cross and Blue Shield, has resulted in a reasonably high level of insurance coverage and greater utilization of the hospital. Our most recent organized insurance campaign brought nearly 1,000 additional persons under Blue Cross protection.

The hospital is a member of the Blue Cross plan. It is registered by the American Medical Association and is a member of the Tennessee Hospital Association and the American Hospital Association. An American College of Surgeons' survey is to be made in the near future.

The medical staff organization is one of the best to be found in a small hospital. The attending or active staff consists of two doctors certified by the American Board of Internal Medicine, two general surgeons who limit their practice to their specialty, and six general practitioners. Fourteen consulting specialists, all certified, come from Knoxville and Oak Ridge. These specialists, several of whom conduct monthly clinics at our hospital, do much in support of our attending staff and in the interest of better medicine for our rural area. They are called frequently, and though they may occasionally find it awkward to travel to Crossville (Oak Ridge is 60 miles distant, Knoxville, 74), not a single call has gone unheeded. The cooperation of these doctors has been remarkable and of great value to our community.

AUXILIARY GROUPS

One of the most important and constructive units making up our total organization is the women's hospital auxiliary. It now has a membership of 65, representing all sections of Cumberland County. Their services include helping on the nursing service (eight registered nurses are members of the auxiliary), housekeeping inspection, making special dressings and packs, special duty nursing on critical cases and hospital interior decoration.

In the disaster plan, which provides for care of 134 bed patients under emergency condition, this organization plays a very important part. In the event of a catastrophe resulting in large numbers of patients being rushed to the hospital, the auxiliary would stand as an indispensable bulwark in every department of the hospital.

Another important unit is the civic advisory board of 11 Cumberland County businessmen who technically are without executive authority but, through their advisory functions, nonetheless are a positive influence with regard to the management policies of the hospital.

Such influence by the average non-authoritative hospital advisory board is possible and proper only when there is complete harmony and unity of purpose among all concerned with the direction of the hospital.

DEPARTMENTAL STAFFS

Our personnel organization has been called a model of efficiency and departmentalization for the smaller type hospital. The hospital now has on its staff 40 employees, handling an average daily census of 26 patients.

On our nursing service are six registered nurses, one of whom is the head nurse, plus two licensed practical nurses, five experienced and well-trained aides, and one male nurse attendant. The department is segregated into four basic services—medicine, surgery, obstetrics, and isolation (medical, surgical and pediatrics).

The surgical supervisor and scrub nurse is a registered nurse with many years of training in operating room technique. She is assisted in minor work by a trained aide and by one of the auxiliary's registered nurses who circulates on major surgery.

Total operating costs	Total operating revenue	% of earnings to cost	Operating deficit
7,574.34	2,042.44	27	5,531.90
11,408.69	6,398.00	56	5,010.69
11,609.91	4,989.96	43	6,619.95
12,019.38	8,796.19	73	3,223.19
12,508.20	7,577.11	61	4,931.09
11,795.71	7,578.30	64	4,217.41
11,621.78	8,524.42	73	3,097.36
12,530.34	7,321.08	58	5,209.26
11,501.62	8,371.72	72.7	3,129.90
11,960.14	9,946.99	83.1	2,013.15
13,450.81	12,992.63	96.5	458.18

All intravenous procedures and most medications are administered directly by registered nurses. Licensed practical nurses give medications within appropriate limits, and nurse aides none at all. Rigid sterile techniques are practiced throughout the services, with scrupulous care being taken in the segregated obstetrical section.

The clinical laboratory is staffed with two registered technicians, both certified by the American Society of Clinical Pathologists. One acts as relief x-ray technician and alternates on call in both the x-ray and laboratory departments. The laboratory, doing procedures at a current rate of 1,000 a month, is under the supervision of a Knoxville pathologist to whom all tissue is sent for examination.

The x-ray laboratory work is handled by a registered x-ray technician, who also acts as part-time nurse attendant. This department is under the supervision of two Knoxville radiologists who alternate in conducting monthly clinics at our hospital.

A registered nurse anesthetist with 20 years of experience in the administration of all types of intravenous and gas anesthesias is in charge of the anesthesia service and oxygen therapy. Of the more than 525 surgical and obstetrical patients we have treated since the hospital opened, not one has had an unfavorable reaction due to anesthetic—a record we consider remarkable. The anesthetist, who is well paid (as are the other technicians), is on 24-hour call seven days a week. Periodically we bring in a relief anesthetist from one of the urban medical centers for a few days to give our regular anesthetist a break in routine and a chance to rest for awhile.

In our medical records department we have a record librarian who, while not registered, has been well trained in quantitative and qualitative chart analysis, coding, and statistical record keeping by a registered record librarian whom we employed for a time on a consultant basis.

FOOD SERVICE

The dietary department is presided over by an expert registered dietitian. From the day our hospital opened she set about to make the food service second to that of no other hospital, and we think she has accomplished just that. An opinion poll recently taken of some 450 former patients with regard to the services of the hospital resulted in more than 200 replies, all expressing satisfaction with the treatment received, with emphasis on the high quality of the food service.

In addition to the dietitian, this department is staffed with two cooks and four maids who handle the patient food service and cafeteria. Part of the salary consideration of all employees is meals while on duty. The value of the meals is added to their base pay and deducted from the paychecks and credited to cafeteria earnings. Because of the quality of the food service, employees are quite satisfied with this arrangement.

The service departments, including laundry, housekeeping, and building maintenance, are costed separately but are flexibly organized to permit interchange of employees between each of the services. There are 11 employees (one a foreman) in the three departments, each of them familiar with the work of the others. It is doubtful whether higher quality performance could be found among service personnel of any institution.

The business office functions 14 hours daily, seven days a week, and is capably handled by an accountant, two accounting clerks, and a part-time stenographer. Our accounting method is the accrual type and conforms to generally accepted commercial accounting practices. It closely follows the pattern recommended by the American Hospital Association.

This refinement of hospital organization and service has not been without the tribulations to be expected in the development of a new institution that is without local precedent. It has been and is a financial problem for our small community. The service rate structure of the Cumberland Medical Center (approximately 15 per cent lower than existing rates in the larger cities of the state) is designed to produce earnings equal to operating costs on a utilization rate as low as 65 per cent of its bed complement.

FIRST FINANCIAL DATA

From the inception of operations on March 19, 1950, to the close of our fiscal year, Oct. 31, 1950, approximately seven and one-half months, total operating costs amounted to $92,356.17, which included $5,100 representing preopening expense dating from Jan. 1, 1950. This figure exceeded our March budget estimate by $4,203.17. The estimate was $88,153.

During the same period, total earnings amounted to $53,179.27, representing 57 per cent of operating cost. The budget estimate projected total earnings of $78,723, based on 62.6 per cent average occupancy at an average earning of $10 per patient per day. The actual occupancy for the period was only 27.6 per cent with actual earnings of $14.38 per patient per day for direct inpatient services. Earnings from all revenue-producing services, including inpatient, outpatient, cafeteria, quarters rental and discounts, amounted to $17.35 per patient day. Of total earnings stated above, $9,468, or approximately 18 per cent, represented accounts receivable from patients at the close of the operating period.

At the beginning of operations it was estimated that during the first seven and one-half months 1,389 patients would be admitted for an average hospital stay of five days, or a total of 6,945 patient days of service. Actual admissions were 646 for an average stay of four and seven-tenths days or a total of 3,065 days of service. Average cost per patient day was estimated at $12.69, based on 6,945 days and 62.6 per cent utilization. Actual

cost was $30.13 per day per patient, since the occupancy rate was only 27.6 per cent. The estimated deficit for the period was $9,430. The actual deficit amounted to $39,176.90, indicating a subsidy of $12.78 per patient per day.

It is apparent from the foregoing statistics that a constant occupancy rate of not more than 65 per cent (divided equally between surgical and medical patients) would result in the financial break-even point, including allowance for an increase of more than 20 per cent in overall cost. The current trend is definitely toward the necessary utilization, as will be shown by the accompanying table which includes statistics for November, December and January, as well as for the seven and one-half month period we have been discussing.

As the Cumberland Medical Center emerges from what might be termed its shakedown period of operation, the outlook for its future appears brighter, both economically and from the standpoint of service to the community.

FUTURE PROSPECTS

It is likely that a rapid turnover of patients will continue and that the daily patient census will exceed the average of 20 estimated in our budget for 1951. This certainly will be the case if changes in certain existing conditions adversely affecting the hospital can be brought about. These changes would be the elimination of beds (used for maternity and other patients in the same strict sense that a hospital bed is used), the prohibiting of administration of general anesthesia in the doctors' offices, and the diverting to the hospital of much of the diagnostic work now performed in the offices of those doctors having x-ray and laboratory equipment.

The staff doctors, of course, will have to agree unanimously to these changes before they can be made. Since our doctors recognize their responsibility to the hospital and realize that their support is urgently needed, it is likely that proper adjustment will be made.

USE OF TAX FUNDS

During the critical period of development lying ahead, a five-mill hospital tax, to be included in the Cumberland County property tax assessment, will provide funds to help defray anticipated deficits. A bill authorizing this tax levy recently was approved by the state legislature. Another bill, now pending in the legislature, would authorize a 10 per cent city and county tax on all beer sold. It is probable that this bill will be enacted. Funds from this source, together with those derived from the property tax, should adequately support the hospital.

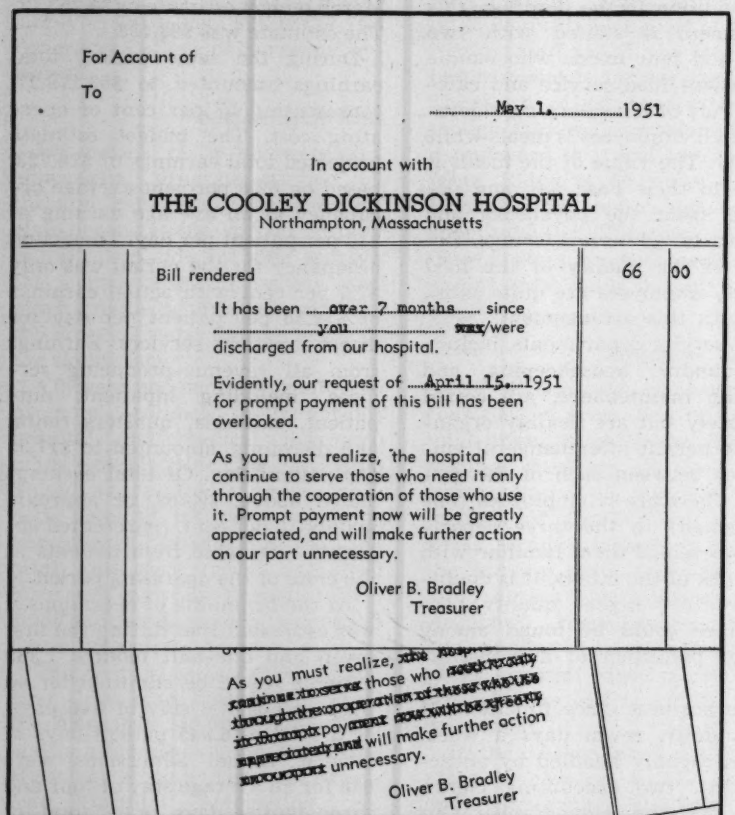
ONE FOR THE RECORD

Selected sentiments

ANY ADMINISTRATOR can remember a good joke—especially if it might cost his hospital $61. One administrator recently received $5 (as payment for an overdue bill of $66) with unforgettable deletions on the hospital's own statement.

The patient's message—composed by blocking out parts of the hospital's goodwill note—was quite plain: "As you must realize, those who pay will make further action unneccessary."

A copy of the original statement is shown below superimposed on the patient's ingenious job of editing.—*Submitted by* WILLIAM T. LEES JR., *administrator, Cooley Dickinson Hospital, Northampton, Mass.*



For Account of

To

May 1, 1951

In account with

THE COOLEY DICKINSON HOSPITAL
Northampton, Massachusetts

Bill rendered	66	00

It has been over 7 months since you were discharged from our hospital.

Evidently, our request of April 15, 1951 for prompt payment of this bill has been overlooked.

As you must realize, the hospital can continue to serve those who need it only through the cooperation of those who use it. Prompt payment now will be greatly appreciated, and will make further action on our part unnecessary.

Oliver B. Bradley
Treasurer

As you must realize, those who
prompt payment will make further action
unnecessary.

Oliver B. Bradley
Treasurer

Any good anecdote is one for the record. Share yours by sending it to "One for the Record," editorial department of HOSPITALS, *18 E. Division Street, Chicago 10.*

RECOGNITION OF A DUTY

The hospital and the press

EDGAR C. HAYHOW, PH.D., FACHA

SOME TIME ago a storm of hurricane proportions hit a certain section of the country. Transportation, telephone service and power were disrupted in many communities. Practically every office closed to let employees return to their homes. The word "hospital" appeared 76 times in one issue of a newspaper, but what paper called attention, editorially or otherwise, to the fact that, despite the disaster, the hospital stood ready as always to be of public service?

Hospitals will play a great role in the present defense program, but already they are faced with critical shortages of essential materials, equipment, and professional and nonprofessional personnel. It would be criminal for the nation to neglect its hospitals. The hospital story must be told and who is better equipped to do it than our press?

Hospitals and the press both are service institutions and both have a duty to the same public, but hospitals also have a duty to the press, as stated in the Iowa Hospital Code: "The public is hungry for hospital news because health touches every family. . . . Hospitals have a great story to tell. It is their service to better health."

The administrator who fails to inform the public of the hospital's progress, service and problems is, in my opinion, failing miserably in his duty.

In giving out news, the hospital should guard the interests of the patient, but it should recognize that suicides, accidents and the like are public information to which the press is entitled. I am aware of the barred-door tactics of some hospitals who have a "no stories to tell" or "resting comfortably" attitude. I am equally aware of the occasional neophyte reporter who thinks his rights and privileges are preordained and rushes onto a hospital floor demanding information from a nurse.

Cooperation between hospital and press is necessary, and since the hospital needs the press more than the press needs the hospital, it is up to us, as administrators, to further mutual understanding by learning the policies of the papers with which we deal, by visiting their offices and plants, and meeting the newspapermen personally. We should invite them to hospital functions and take them on personally conducted tours of the hospital to see "behind the scenes." We need to establish codes of mutual relationships and develop daily communication systems with deadlines always kept in mind. We must make sure the press knows both sides of stories such as ambulance delays or lack of beds in order to avoid sensationalism.

GOOD AND BAD EXAMPLES

A policeman brought a colored child to a hospital's emergency room and found it was already occupied. Overhearing a phone conversation, he assumed there were no beds at all available in the hospital. When the nurse on duty called for the patient, he apparently had disappeared.

The next report of the incident was a scathing story in the local paper announcing the child had been refused admission and had been taken to a neighboring hospital in a critical condition. A paper of wide distribution picked up the account with editorial comment. Later it was learned that the telephone conversation was by a woman intern who had phoned and learned that there were no beds at the moment in the gynecological section. Such was not the case in the children's ward. The editor and owner of the newspaper were contrite and did publish corrected articles, but two years later the hospital was still hearing about the case of "that colored boy."

We agree with the press that there is a human side of the news, but coverage should be done with maximum gravity, dignity and effect.

A tragic accident, in which a small child was involved, occurred in a hospital. As soon as he could, the administrator called the newspaper and related all the facts. He added that there were thousands of little children in hospitals at that very moment and many more to be admitted in the near future. He asked the editor to think of all the mothers who would be worried by a detailed account of the accident. In the next edition was the editor's answer—two small lines on an inside page.

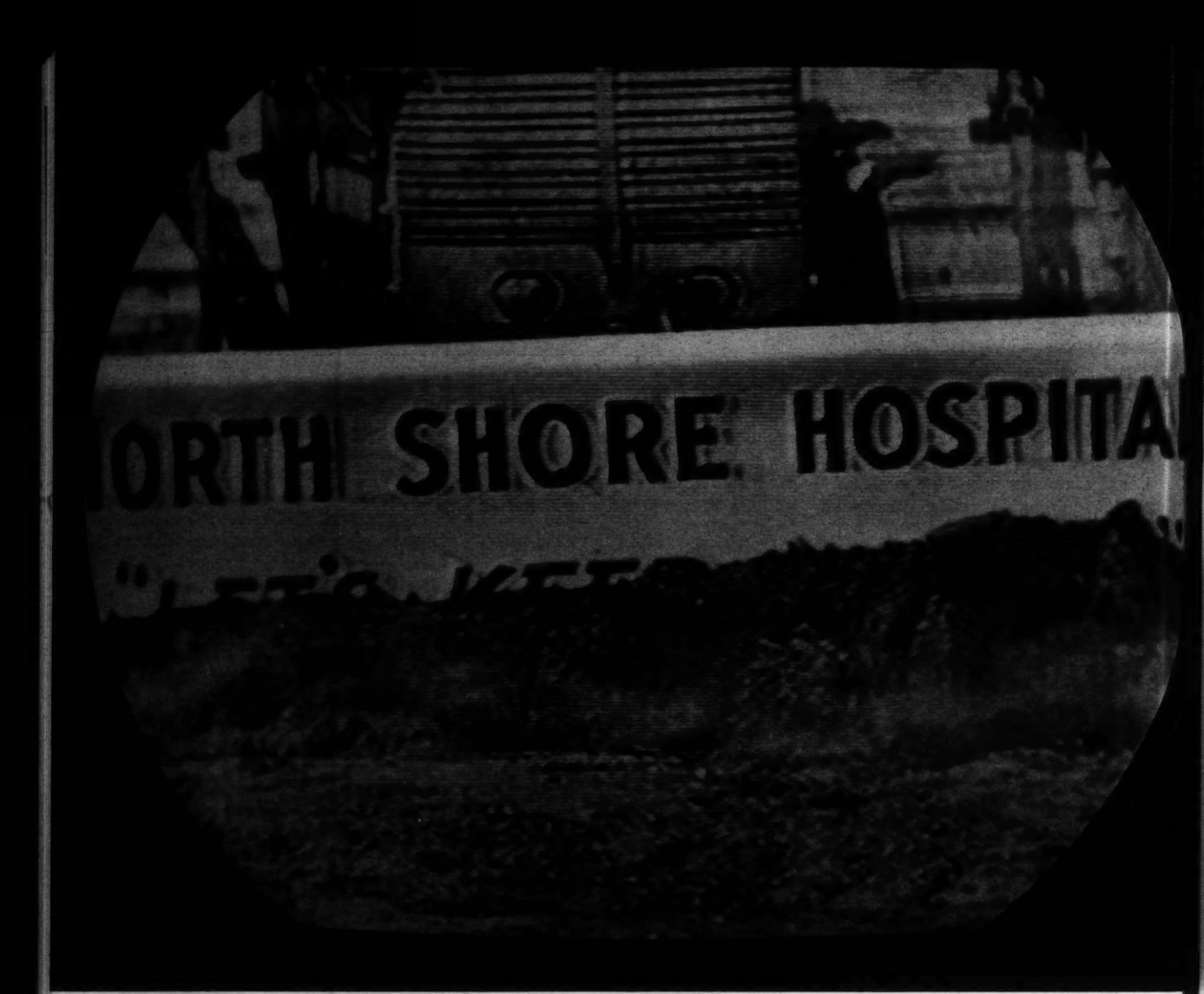
Stark facts may be sensational and attract readers, but the effect of a story must be considered.

I recall an incident of a news photographer requesting a picture of a patient. The situation was ghastly and undue publicity would benefit no one. Since it was a police case, permission was granted, but the photographer was reminded that the patient very well could be his wife, sister or daughter. He was escorted to the patient's bedside, but no picture was taken.

A great many news stories happening daily in hospitals are unpublicized. Many hospital administrators and personnel are not alert to what is a "natural" for news appeal. A simple incident may attract nationwide notice.

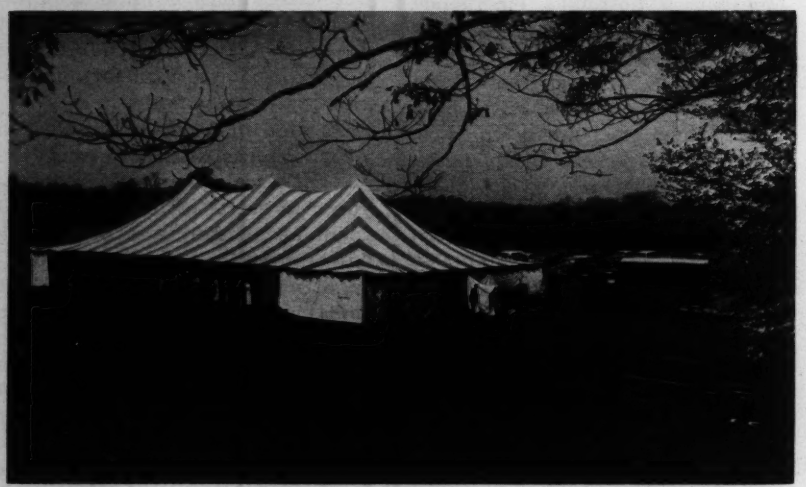
A blind man was admitted to a hospital. A short time later, the patient's seeing-eye dog, who refused to eat after being separated from his master, was brought to the hospital for a visit. An appointment was made for a news reporter and photographer to be on hand. The result? A dramatic story with terrific public appeal. This news item was reprinted in hundreds of papers all over the nation. The story also resulted in a public relations gain made possible only by the hospital's alertness and cooperation with the local newspaper.

Mr. Hayhow is director of East Orange (N.J.) General Hospital. Adapted from a paper presented at the northern conference of the New Jersey Hospital Association at Newark, February 1951. Mr. Hayhow is chairman of a joint commission appointed by the New Jersey Associated Press and the New Jersey State Hospital Association to develop a code of effective press relations to be used as a guide for individual papers and hospitals.



GROUND-BREAKING

. . . a fund-raising potential



A CATERER served noon brunch to selected guests seated inside a colorful green and white striped tent. The luncheon area was set in a field adjacent to the hospital site.

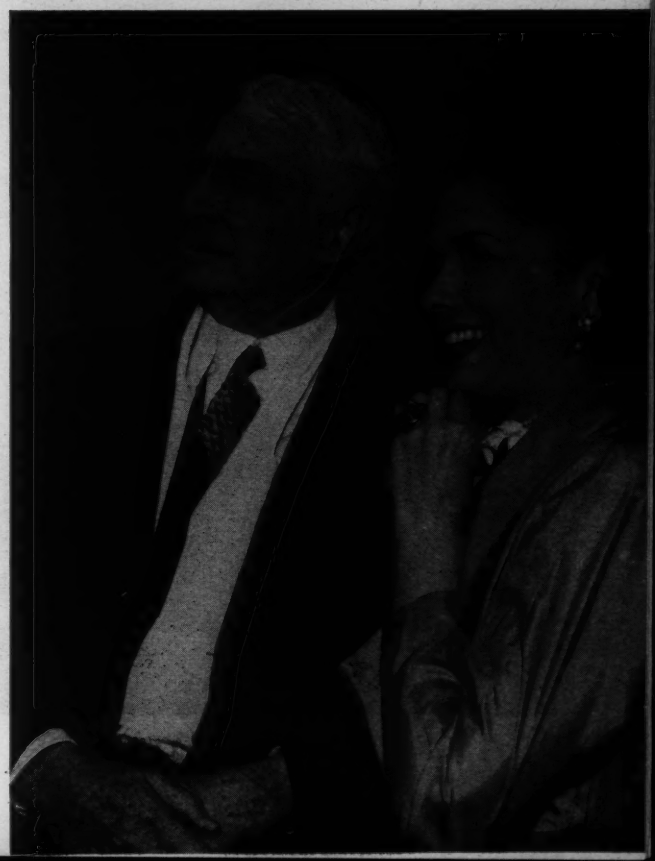
EDWARD E. JAMES

THE NORTH SHORE Hospital Fund in Great Neck, Long Island, N. Y., had been raising money for construction of a nonprofit hospital for several years. Despite the difficulty of fund raising in communities with split interests, where nearly every wage earner is a commuter, the largest capital gift fund in Long Island history had been built up.

In the previous year alone, a million dollars had been collected

Mr. James is director of the North Shore Hospital, Great Neck, Long Island, N. Y.

FLANKED by honor guards from nearby military camps and by color guards from legion posts and the Boy and Girl Scouts, the hospital vice president, Thomas W. Fitzgerald, welcomed audience and told of efforts already made in raising money for the hospital.

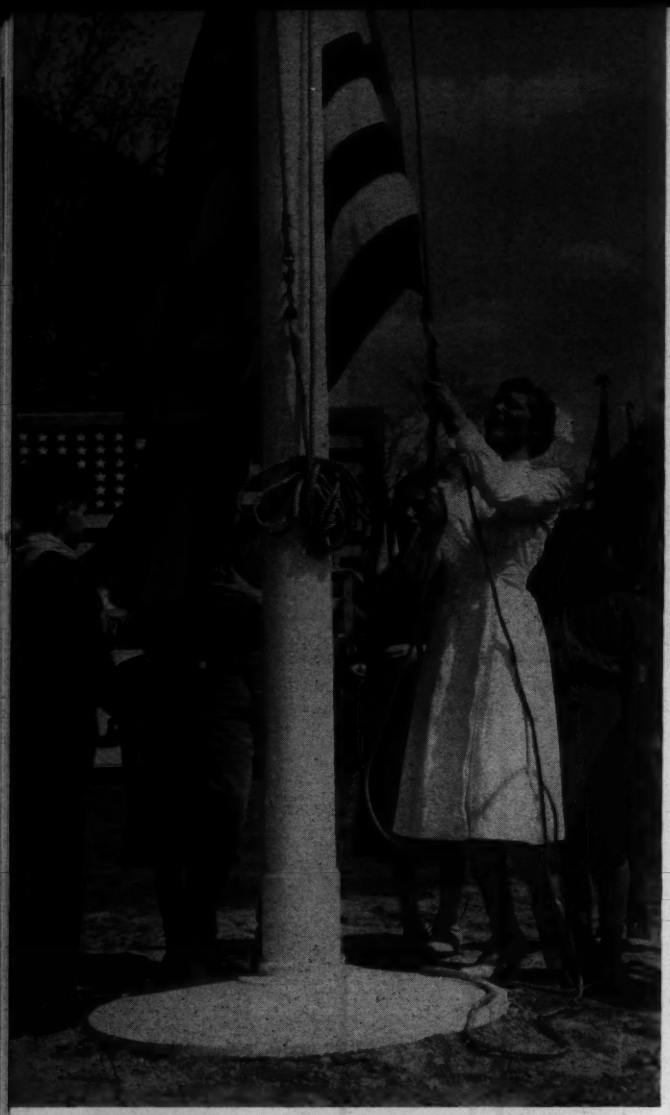


MOVIE actress Paulette Goddard (above) receives last-minute instructions from TV directors. State Attorney General Nathaniel Goldstein; Jinx Falkenburg McCrary; Jay Jostyn, radio's "Mr. District Attorney," and Congressman Leonard W. Hall (above, right) discuss community's health status. Elder statesman Bernard Baruch and Jinx McCrary (below, right) listen to the welcoming addresses.

(incidentally, at an overhead expense of only five per cent). Directed by Tex McCrary, television and radio personality and newspaper columnist, the fund-raising campaign had been advancing satisfactorily.

But something new was needed to rekindle public interest in the project. Actual construction was scheduled to begin in July. It was obvious that a ground-breaking ceremony of some sort would have to be held, and it was decided, in order to capitalize on the money-raising potential, to break with tradition in staging the event.

Ground-breaking offered a unique publicity opportunity with the chance to tell of the need for a hospital and the way that need was being met. The ground-breaking ceremony itself could be made into a newsworthy event through which the public could



BUFFET service and random seating afforded relaxed atmosphere. Blue and white center strip on tables showed hospital floor plans.

be reached—in daily and weekly newspapers, over the radio, and on television.

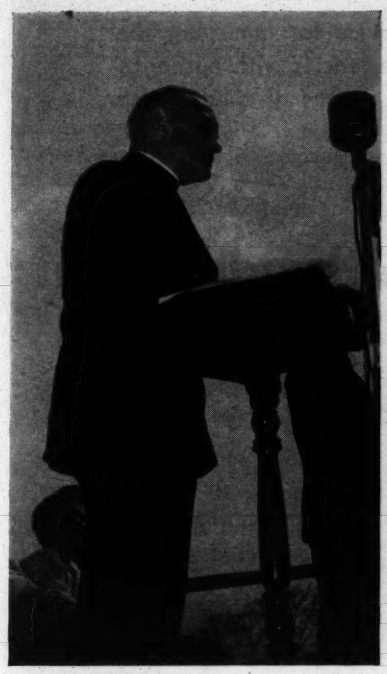
Since in fund-raising nothing succeeds like success, a convincing ground-breaking can be powerful in helping a hospital realize its fund-raising goal.

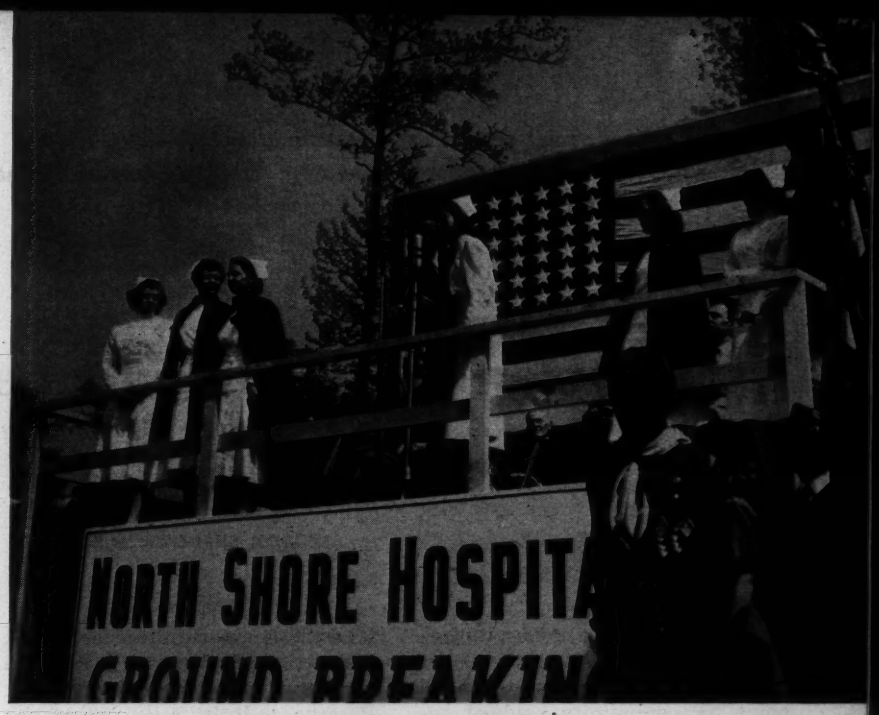
Ground-breaking for the North Shore Hospital took place on May 6. The day—a Sunday—was clear.

The event started with a noon brunch for selected guests, served under a colorful green-and-white striped tent. No speeches were made, only brief welcoming addresses. Tex McCrary and his wife, Jinx Falkenburg, broadcast their regular Sunday radio show from the brunch, interviewing prominent guests.

A small crowd gathered at the site, but most of the spectators saw the ground-breaking ceremonies from

AFTER massed high school glee clubs sang "Battle Hymn of the Republic," a retiring "Miss Hospital" (top, left), assisted by Boy and Girl Scouts, raised flag on the flagpole, first part of the new hospital to be erected. Loudspeaker system fed from National Broadcasting System directional microphones (below) let audience hear as well as see all that went on. Nineteen technicians and engineers were needed at site to broadcast and televise the ground-breaking. To demonstrate by contrast the range of community support, Tex McCrary (below, right), the fund-raising campaign manager, interviewed two school children representing a classroom store that raised $12 in a year for the building fund.





HIGH school juniors, elected from four different areas each year to serve as "Miss Hospital," pledge to accept responsibility for helping hospital for the ensuing year.

CLERGYMEN representing the Protestant, Jewish and Catholic faiths (above) asked guidance and aid for the new non-sectarian, inter-racial hospital. The hospital president, Mrs. Charles S. Payson (below) is interviewed by Jinx and husband Tex McCrary.

SUDDEN appearance of bulldozer came as a surprise to the television audience at home. The slogan, "Let's Keep Digging," was a reminder of the fund-raising yet to be completed.

their living rooms—on television. The National Broadcasting Company telecast the event as a public service.

To show the range of community support, Tex McCrary interviewed two school children representing a classroom store that had raised $12 in a year for the building fund, then he interviewed a chain-store manager who gave $1,000. (Last fall, area school children helped collect 250,000 pennies for the fund). The financial highlight came with the announcement of a gift of $500,000 (to be matched by the community) from Trustee John Hay Whitney and his sister, Mrs. Charles Payson, president of the hospital.

As a finale, a bulldozer appeared from behind a nearby hill and with its blade turned the first "shovelful" of earth. The bulldozer was selected in place of the traditional shovel because it symbolized modern efficiency.

One month after the ceremonies, $240,000 had been received in cash or pledges. Of this, $120,000 is from the gift to be matched.

Medical social service is now extending into the field of parent education. The Children's Medical Center in Boston has developed a service for furnishing the press and other agencies with authoritative data on all phases of child health.

A new plan for community health education

LENDON SNEDEKER, M.D.

As the frequency of hospitalization has increased, the hospital has become more and more the focal point for community-medical activities. Not all of these activities have been limited to the collection of clinical laboratory information or the application of special physical or psychological techniques.

A diversity of techniques and technicians and a high degree of medical specialization, all operating in an institutional setting, have tended to weaken the personal relationship between the doctor and his patient and have reduced opportunities for those warm human relationships so necessary in treating the sick and advising members of the family responsible for aftercare. In view of this, increasing attention has been paid to "humanizing" the hospital.

MEDICAL SOCIAL SERVICE

Medical social service has long been recognized as an essential hospital function in adjusting the patient and his family to the problems which illness creates. In the case of hospitals for children, the importance of the parent-child relationship is being given more recognition. Provision for the maintenance of normal play and education have been increased. All this has provided opportunities for giving parents insight in the meaning of illness, for themselves as well as for their child, at a time when they are most apt to be receptive to advice and instruction.

It is possible to improve and extend these opportunities for parent instruction. The many preventive aspects of child care are obvious. Parents eagerly take action for their children when they will not do it for themselves. It is often possible to take positive and beneficial action early in the child's life for the improvement of his health. All these are factors tending to make such work most productive in the field of pediatrics.

The hospital which deals with children is in a position to develop a program of health education as one part of its obligation to the community. It can help parents to deal with their personal and family problems. It can furnish authoritative information on many phases of child health to such agencies as the press. It can also assume leadership in cooperation with other educational institutions in meeting the physical and emotional needs of children.

NEW SERVICE CREATED

For the purpose of developing such a program, the Children's Medical Center has created a medical information and education service. This functions under administrative direction as a part of the work of the department of public relations. This service is responsible for the maintenance of a reference library and for the preparation of printed material and audio-visual aids. It is prepared to furnish the press and other public information agencies with authoritative data on all phases of child health.

For a good many years, members of the hospital staff have individually answered requests made to the hospital for providing speakers on health subjects. Many of these requests have come from mothers' clubs or from parent-teacher associations.

Requests for this type of service are now routed through the director of public relations who assumes responsibility for securing speakers and, to a large extent, choosing the subjects covered. The Medical Information and Education Service is prepared, when called upon, to provide source material for members of the staff and is accumulating lantern slides for use at such gatherings. There is considerable opportunity for improving this service and answering a real educational need.

Parents are already receiving considerable attention on the medical wards of our hospital where they have considerable freedom with regard to visiting hours and where they have a chance to help in caring for their children. At the same time their presence creates opportunities for learning the meaning of illness for their particular family group. A nursery school teacher, working under the hospital psychiatrist, is a member of the team which deals with these parents. Not only does she provide education and diversion for each child but she is on hand to answer questions and help in interpretation.

SYMPOSIA FOR PARENTS

A series of symposia for parents is also planned. These will deal

Dr. Snedeker is the assistant administrator of The Children's Medical Center, Boston.

with the meanings of illness of various types, explain the problems accompanying hospitalization, and suggest ways in which children can be helped to adjust to a hospital experience. Such a program can be easily diverted from the immediate problems of illness to the broader aspects of health education.

It is not intended that the medical information and education service should duplicate or displace the work of the visual education committee of the hospital staff, which limits its activities to that part of medical education for the professional worker and is concerned with the development of visual material and exhibits for medical meetings. These two agencies are working together in developing the hospital's total program of health education.

The work of the medical information and education service is in a very early stage of development, but already experience with one type of project has been so productive of good will and cooperation that it is felt a description of its nature and scope is worth reporting here.

CAMPING CENTER

The Children's Medical Center is a general hospital serving children from all of New England, and from many more distant points. It is in contact with a large number of physicians and institutions in this area. Furthermore, New England is one of the most active centers in the country for summer camping for children. The New England Camping Association, a regional division of the American Camping Association, represents over 275 camps in New England. In addition there are 92 camps operated by the social agencies in the Greater Boston area which are organized through the camping section of the United Community Services of Boston.

FIRST SYMPOSIUM

Feeling that camp directors would be interested in obtaining authoritative information about the management of children's problems, the center last year inaugurated an all-day symposium to which members of these camps were invited and at which they were addressed by members of the hospital staff. All papers were brief and were followed by a discussion period. The program was sponsored also by the president of the New England Camping Association, Bradford Bentley, and the representative for United Community Services, Robert Rutherford.

The proceedings of the meeting were reported and a digest sent to each of the members of the camping association. These were subsequently published in two numbers of the *Camping Magazine*. The public's response was most enthusiastic.

This year a second symposium was held at which the attendance was more than quadrupled and which met with the same enthusiastic reception. The audience was invited to participate in the general discussion at the conclusion of each paper.

INFORMATION NEEDED

The reception accorded the two meetings leaves no doubt that camp directors are keenly interested in the welfare of children and that they are anxious to obtain authoritative information at first hand regarding sound procedures to be followed in meeting their responsibilities. It is felt that a teaching hospital like the Children's Medical Center is exceptionally qualified to provide such information. Spontaneous interest of this type is more apt to be productive of sound health education than the creation of the usual liaison committees committed to the development of "standards" which may be far removed from the actual problems which the children present during their summer camp experience.

MEMBERS of the hospital staff addressed an all-day symposium for personnel of the many children's summer camps in the state.

ANOTHER EXTENSION OF SERVICE

A home follow-up plan for care of premature infants

INTENSIVE WORK has been done in New York City to strengthen and expand the home follow-up program for premature infants, now operating in a number of hospitals with the assistance and cooperation of public health nursing agencies.

A few statistics will illustrate the extent of the premature follow-up program. Each year there are approximately 13,000 premature infants born alive in New York City's five boroughs, and 7,700 of these premature infants are born in the boroughs of Manhattan, Queens and Bronx. In 1948 approximately 1,200 premature infants were referred by hospitals in Manhattan, Queens and Bronx, to the central office of the Visiting Nurse Service of New York for home visiting. In 1950, hospitals in Manhattan, Queens and Bronx referred approximately 3,000 premature infants to this same office.

All participants in the program, including the Woman's Hospital, have been enthusiastic about its accomplishments. The follow-up program for prematures has been adopted by the New York City department of hospitals for all 13 of its municipal hospitals with maternity and newborn services. It is also being presented to the Greater New York Hospital Association for adoption by its 65 member voluntary hospitals. The growth of the service to the present time reflects its value.

There are sound reasons why a hospital should develop an effective home follow-up program for premature infants. The hospital is concerned with both the reaction of the mother to her new responsibility and the physical aspects of the care of the infant. The expert pediatric and nursing care of a premature infant in the hospital sometimes has been negated because the infant was discharged to an unsuitable or unprepared home and developed an infection which led to serious illness and death.

In a large metropolitan area, it is not unusual to find in the home relatives and children with communicable infections, homes with lack of heat in very cold weather, and homes with a lack of physical equipment to take care of an infant. If such conditions are known to the hospital staff prior to discharge of the baby, assistance can be given to the family and preparation made to receive the baby from the hospital. A story will illustrate the need of home follow-up from the point of view of physical care.

A mother of three children delivered tiny twins in a New York City hospital. The twins remained in the hospital several months until they had gained enough weight to be sent home. When the twins were discharged, the three other children at home had upper respiratory infections and *otitis media*. The twins developed upper respiratory infections and severe diarrhea, and were readmitted to the hospital where they died shortly after readmission. A visit to this home by a public health nurse would have revealed the potential danger and would have resulted in the continued hospitalization of the twins until the siblings had recovered.

Inasmuch as many communities already have public health nurses visiting homes for a wide variety

This article was prepared under the joint authorship of Dr. Karl S. Klicka, director of St. Barnabas Hospital, Minneapolis, formerly director of Woman's Hospital, New York City; Dr. Helen M. Wallace, chief of the maternity and newborn division, New York City Health Department; Margaret A. Losty, R.N., hospital nursing consultant, New York City Health Department, and Ethel M. Donny, R.N., maternity consultant, The Visiting Nurse Service of New York.

of services, it is reasonable and efficient that home follow-up programs for premature infants should be developed and integrated with other services. Such a plan prevents duplication of service.

In the New York City program the hospital personnel responsible for home follow-up consists of a three-way team: The pediatrician-in-charge of the premature nursery and his pediatric house staff; the nurse-in-charge and nursing staff of the premature nursery, and a member of the social service department. Each of the hospital staff members involved makes an important and pertinent contribution to assure that home visiting by the public health nurse will be intelligent, helpful and effective.

Guiding the participation of staff members in the program is the *inter-agency referral form* used for the referral and home follow-up of all hospital patients in New York City. It is a relatively simple form that has been adopted by most of the New York City community agencies. On it are the following sections: (A) Identifying data on the patient; (B) a medical section for the hospital physician's orders and instructions; (C) a nursing section for hospital nursing data on the patient; (D) a social service section for hospital social service data on the patient; (E) a section for the public health nursing report of home visits.

Routing of the inter-agency referral form in the hospital is dependent to some extent upon the individual family-premature infant complex and their particular problems. In general, however, the following routine is practiced.

1. The form is initiated by the nurse-in-charge of the premature nursery at the appropriate time.

2. The respective sections of the form are filled in by the pediatrician-in-charge of the premature nursery or his pediatric house officer and the nurse-in-charge of the premature nursery.

3. The nurse-in-charge of the premature nursery contacts the hospital social service department to find out if the family is known to that department or if there is a known social problem. If there is a known social problem, the form is sent to the hospital social service department for filling in the social service section of the form. The form is then mailed directly to the public health nursing agency.

If there is no known social problem, the nurse-in-charge of the premature nursery mails the form directly to the public health nursing agency.

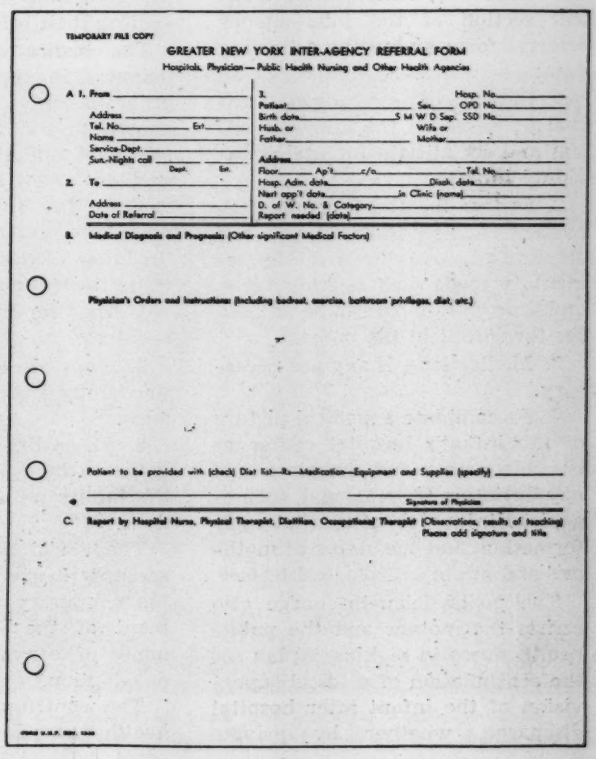
4. After the home visit by a public health nurse, the form is returned to the premature nursery where it is reviewed by the pediatrician and attached to the infant's hospital record. A copy of the form is retained by the public health nursing agency and is used as a basis for assistance to the patient in the home and for future home visits.

Both the initiation and intensity of the home follow-up program depend upon the expected length of stay of mother and premature infant in the hospital.

In the case of the larger premature infant (five pounds and over) who has an uneventful hospital course and who would usually be expected to go home with his mother six or seven days after birth, the referral to the public health nursing agency is made a day prior to hospital discharge. The pediatrician-in-charge and the nurse-in-charge of the premature nursery and the hospital social worker have time to confer with the mother during her hospital stay, ascertain her medical and social problems, and assist her in making a plan for their immediate and long-range solution.

All information collected in the hospital regarding such problems is relayed by telephone to the public health nursing agency one day before the hospital discharge and recorded on the inter-agency referral form which is sent to the public health nurse agency. The home visit is made by the public health nurse within 24 hours after hospital discharge to assist the family with the care of the infant at home. The report of her findings in the home is returned on the inter-agency referral form to the premature nursery, and the form is incorporated into the infant's hospital record.

In the case of the smaller premature infant, there is opportunity to do a more extensive type of



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GREATER NEW YORK INTER-AGENCY REFERRAL FORM

Hospitals, Physician — Public Health Nursing and Other Health Agencies

A 1. From

Address

Tel. No. Ext.

Name

Service-Dept.

Sun.-Nights call Dept. Ext.

2. To

Address

Date of Referral

3.

Patient Hosp. No.

Birth date S M W D Sep. OPD No. SSD No.

Husb. or Wife or

Father Mother

Address

Floor Ap't c/o Tel. No.

Hosp. Adm. date Disch. date

Next app't date in Clinic (name)

D. of W. No. & Category

Report needed (date)

B. Medical Diagnosis and Prognosis: (Other significant Medical Factors)

Physician's Orders and Instructions: (including bedrest, exercise, bathroom privileges, diet, etc.)

Patient to be provided with (check) Diet list—Rx—Medication—Equipment and Supplies (specify)

Signature of Physician

C. Report by Hospital Nurse, Physical Therapist, Dietitian, Occupational Therapist (Observations, results of teaching) Please add signature and title

BASIC information for each case is recorded on the referral form. The medical social worker and public health nurse write reports on the reverse side.

home follow-up because the infant usually remains in the hospital a longer period of time. Again during the mother's postpartum hospital stay, the pediatrician-in-charge and the nurse-in-charge of the premature nursery and the hospital social worker have opportunity to confer with the mother. At the time of the mother's discharge from the hospital, the inter-agency referral form is sent by the premature nursery nurse to the public health nursing agency. The public health nurse visits the home at least once and thereafter as many times as necessary to evaluate home conditions and to assist the mother in preparing for the baby's care at home.

The report of home conditions and family situation is sent on the inter-agency referral form to the pediatrician-in-charge and nurse-in-charge of the premature nursery. The decision regarding the discharge date of the infant is based upon the individual infant's hospital record.

Each of the hospital staff members involved in the program has specific responsibilities in carrying out the follow-up program.

The *pediatrician-in-charge* of the premature nursery and his pediatric house staff complete the medical section of the inter-agency referral form giving the following data:

1. Date of infant's hospital discharge, based on the known medical and social data for each individual infant.

2. Orders for the formula, frequency of feedings, type and amount of vitamins and supplementary foods such as fruit juices, and type of skin care to be advised for the infant in the home.

3. Medications, if any are necessary.

4. As complete a medical picture of the infant's hospital course as possible with a full description of any deviation from normal, such as a birth injury or congenital malformation, and the status of mother's and infant's serological tests.

The pediatrician-in-charge also assists the mother and the public health nurse in making a plan for the continuation of medical supervision of the infant after hospital discharge, whether by private physician, hospital well-baby or premature follow-up clinic, or department of health child health station.

A MOTHER learns how to care for her child with guidance from the public health nurse.

The *nurse-in-charge* of the premature nursery initiates the home follow-up program in a discussion with the hospital social worker to ascertain if the family and its possible social problems are known to the hospital social service department. She completes the nursing portion of the inter-agency referral form, and lists the following data:

1. Method of feeding and the infant's reactions to feeding.

2. Reactions of the parents while visiting their infant in the hospital.

The *medical social worker* participates in the home follow-up program only if the family is known to the hospital social department and if there is a social problem in the family. In such instances, the social worker completes the social service section of the inter-agency referral form covering these items:

1. The family's known social problems.

2. Steps already taken to assist the family with their social problems.

3. An outline of the future program to be followed in assisting the family with their social problems.

The social service department assists with such problems as housing, temporary or permanent placement of the infant in a foster home or convalescent institution, or adoption.

The contribution of the *public health nurse* is an important part of the program because her role is to evaluate home conditions prior to the infant's hospital discharge to determine whether and when the family and home are prepared to receive the infant. She assists the family in securing the necessary home equipment for the infant such as clothing, formula supplies if the infant is not to be breast fed, crib, bathing supplies, and provision for warmth and constant temperature of the room where the baby will live.

By supplementing the hospital teaching program for parents of premature infants, the public health nurse can strengthen the parents' feeling of security and assist in dispelling their apprehension. She does this by demonstrations of care of the baby at home, and by instilling confidence in the parents' abilities to care for their infant at home.

If the family has health or social problems, the public health nurse assists with these and helps make plans for the infant's medical supervision after hospital discharge. She reminds the mother of the importance of her own postpartum examination at approximately the sixth week postpartum.

APPRAISAL OF PROGRAM

There has been both qualitative and quantitative improvement in the premature infant home follow-up program since it was first established. The quality, speed and timing of the referral to the public health nursing agency have improved considerably. Priority in visiting premature infants is given by the Visiting Nurse Service of New York.

Many hospitals throughout the United States have established or are establishing special facilities for the care of premature infants. In the past, all too few of the programs for the care of premature infants have included the inpatient hospital care only. The New York City plan supplements inpatient service by placing due emphasis on premature infant care following discharge from the hospital. Furthermore, it represents an excellent example of how voluntary hospitals and agencies can cooperate with the local health department.

New problems . . .

. . . and new ideas

TRENDS, FINDING OUT what they are and what the hospital field should do about them, seem to be the concern of program planners for the 1952 American Hospital Association convention in St. Louis. This is particularly true of the sectional meetings on Wednesday, September 19, the third day of the four-day convention.

"Trends influencing the quality of hospital care," the over-all convention theme, has been used by each of the sections as a springboard into a series of talks by well-informed leaders and group discussion. In addition to nursing service, personnel, food service and purchasing, there will be a joint session with the American Association of Medical Record Librarians. The special session on Blue Cross, planned for Tuesday morning, also represents a program set up to give convention participants a more detailed picture of recent developments than is possible in a general session.

Highly controversial questions frequently are debated at sectional meetings. For example, the morning and afternoon sessions on nursing service feature speakers on the use and duties of practical nurses in caring for the patient and federal aid to improve schools of nursing.

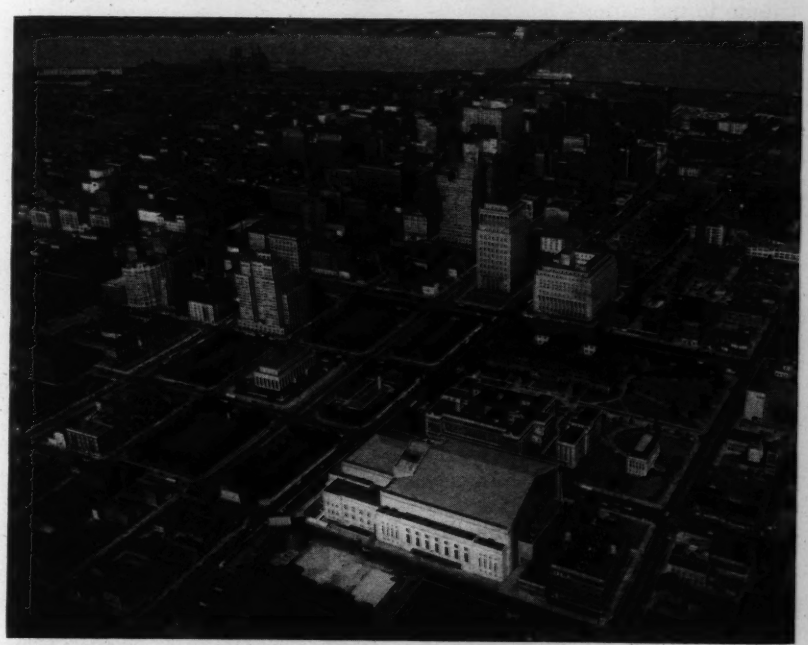
Improved methods, this is the key and current trend toward the improvement of hospital food service, according to planners of the two dietetics sessions. One speaker will suggest the use of modular equipment—equipment such as ice cube trays and cooking utensils sized to fit into service appliances and other equipment—to reduce space requirements and save labor. Another speaker, representing a commercial food service, will talk on the achieving of quality and efficiency in the dietary department.

Personnel problems are among the continuing worries of many administrators. A tightened labor market and demands for higher wages by employees are national trends which hospitals cannot escape. What the hospital can do is offer better training courses and introduce industrial management techniques in order to save money and improve service. At the personnel sections the how and why of these remedies will be examined.

Production controls and allocation of critical materials is one of the timely topics listed on the program of the purchasing section. Another speaker will discuss standardization and the role of the medical staff in carrying out this program.

Blue Cross is in itself an important national trend. Blue Cross representatives at the general session on Tuesday will speak to the specific points of control of utilization and the need for even wider Blue Cross coverage if the nonprofit, voluntary hospital insurance program is to continue growing in importance.

As all those who have attended past Association conventions well know the four-day program presents a panorama of what's happening to hospitals: The problems, the trends, the impacts of government and scientific development, the equipment. At no point in the program, however, is there better opportunity for intensive study of current problems than in the sectional meetings. Here the audience and speaker talk specifically of concrete situations, and the fifty-third convention promises valuable discussions.



IN THIS aerial view of metropolitan St. Louis, Kiel Municipal Auditorium, where most convention sessions of the American Hospital Association will be, is in the foreground.

And now . . . federal permits for construction

With assistance for procuring controlled critical materials

BREMEN I. JOHNSON

IT WILL take more than construction funds and a construction crew to get a hospital built from this point on in 1951. It now requires—and it has been so since May 3—a construction permit from the federal government.

The new program is not expected to reduce the number of hospitals built this year or next. Government planners believe it is a measure that will actually help to get projects completed, since a materials procurement assistance program is to run simultaneously.

The federal government got into the construction picture at an early stage of the current emergency—in January 1951. Its first goal was to put a stop to the building of edifices that would not contribute to the nation's health, welfare or military programs.

Its first order put an end to the construction of amusement arcades, bandstands, dance halls and the like. It also established a list of building projects for which authorization of the National Production Authority is required.

As the supply picture began to tighten and the Controlled Materials Plan was being hurried along, the National Production Authority amended its basic order. The latest amendment was issued May 3. It requires NPA authorization for the construction of hospitals and related facilities, schools, churches, public utilities and similar projects. The logic: If government is to give assistance to make certain that construction can be completed, it must first authorize the project and fit it into its broad planning programs.

Mr. Johnson is director of special services for HOSPITALS.

The construction program under which hospitals find themselves operating is not expected to be unduly complicated. Part of the credit for that can be taken by the American Hospital Association, which was quick to speak out for all hospitals of the country.

A PETITION

Immediately after issuance of the order that unexpectedly brought hospital construction into the control program, an Association recommendation was forwarded to NPA Administrator Manly Fleischmann.

George Bugbee, Association executive director, suggested two alternatives, and one of these was accepted.

He first petitioned that all voluntary nonprofit and state and local government hospital construction be exempted from the terms of the amendment. The request was made because Association officials were gravely concerned about the practical application of the regulations. It was not hard to visualize—under an agency that might know little of the intricacies of hospital service—a program that would actually mean *fewer* hospitals when even more are needed. Said Mr. Bugbee:

"I am sure you are fully aware of the strategic importance of hospitals to the home-front of our country. . . . In the event of a national disaster and a full war economy, hospitals existing today will be woefully inadequate to meet the demands placed upon them. . . .

"Under the Hill-Burton program of federal aid for hospital construction, professional and experienced personnel in every state screen and rule upon applications for new construction under a complex and just formula based largely on priority of need. The program has been praised by experts and consumers alike as an outstandingly successful pattern of federal-state-local cooperation. . . .

"We do not question the necessity for curtailment of excessive use of construction materials in short supply today. Our concern over amended M-4 [which brought hospitals into the authorization program] stems from the delays incident to its implementation and the resulting hardships of *additional* federal sanctions for construction superimposed upon a carefully framed and proved pattern.

"The intricacies of finance involved in hospital construction remove it completely from the sphere of normal building operations. Community fund campaigns, procedures under the Hill-Burton Act, rising costs, and a host of other determinants vitally affect the *timing* of hospital construction.

"Additional delays from approval of construction could well impose psychological blocks and financial penalties upon communities now or soon to be ready for constructing tragically needed new hospital facilities.

"The Defense Production Administration, as you know, has recognized the essentiality of hospital construction by the establishment of a special . . . set-aside program now being ably administered by the Public Health Service as claimant agency. Our hospitals have readily accepted and used the competence of this machinery. Additional controls in this field appear to us as unnecessary at the time."

THE ANSWER

While the petition did not bring about a recision of the order, it did stimulate a decision that may do much to remove the worries that had been expressed by many hospital people. This was the alternative suggested by the Association. The Public Health Service of the Federal Security Agency was de-

signated the agency through which all requests for authorization to construct would be channelled.

Had such action not been taken, the National Production Authority might have faced a situation where it would be necessary to train a large number of "hospital experts" overnight to handle applications and allotments.

ASSURANCES

When informing the Association of the decision, Richardson Bronson, assistant general counsel of NPA said:

"We wish you to know that the National Production Authority is very anxious to maintain the construction of the necessary hospitals throughout the country.

"The Order M-4, by its amendment dated May 11, does affect hospitals, as well as all other construction where the amount of steel made use of in such construction shall exceed 25 tons. In such instances an application is required and a permit must be granted before such construction is commenced. . . .

"The National Production Authority is about to delegate to the Federal Security Agency the responsibility for the administration of so much of Order M-4 as affects the construction of hospitals, schools and similar types of construction.

"In the same manner, Federal Security Agency is the claimant agency for the presentation of the claims for steel, copper and aluminum under the Controlled Materials Plan*, which is to go into effect within the next few weeks [July 1].

"As claimant agency, the Federal Security Agency will be responsible for taking the proper steps to insure that the approved hospital is provided for in the allocation of the controlled materials to be made. The basis and claim for such an allocation will be provided for in a new form, CMP 4-C, which is expected to be adopted within several weeks. Where a hospital is to receive assistance . . . it will also receive priority assistance for obtaining materials not under CMP control required for the construction.

"The net result of the procedure is to have the entire operation handled by one agency and one administration insofar as possible. . . . It is the intention of the National Production Authority to assist wherever possible in approved hospital construction."

THE PROGRAM IN ACTION

This construction program administration that was announced on June 11, a month after the original amendment, now is being rounded into a working plan. It is being geared to the Controlled Materials Plan.

High points of the program are these:

1. *All hospital construction that requires the use of 25 tons of steel must be authorized.* In terms of normal requirements, that means a hospital of 13 beds or more. A hospital not requiring that amount of steel (regardless of number of beds) does not require a permit. The regulation does not affect the building of Veterans Administration or military hospitals.

2. *The application form for authorization to construct will be in two parts; the first is the request for authorization to build, and the second is the request for assistance in obtaining controlled materials.* It is not necessary to petition for materials assistance at the time of filing the request for authorization to build. It will be decidedly to the advantage of the hospital, however, to do so.

Since the materials request will require a statement of the amount of controlled materials (steel, copper and aluminum) needed, the architect and the contractor must be ready to provide these figures at an early date.

3. *If construction was begun prior to May 3, authorization is not required. Construction commencing after that date must be authorized.* Even when authorization is not asked, a hospital construction project which is underway still may request CMP assistance for construction materials.

"Commence construction" means substantial site clearance (including demolition of buildings or structures) preliminary to the start of or incident to the work on a new building, structure or project; or to incorporate into a building, structure or project, substantial quantities of materials which are to be an integral and permanent

*A detailed discussion of CMP planning is the basis of an article beginning on page 80 of HOSPITALS for May.

A new institutional construction record

HOSPITAL AND institutional construction, which last year reached a new high, is pointing toward another record. That is indicated by joint estimates of new construction released by the Department of Labor and the Department of Commerce. Public and private hospital and institutional construction during the first five months of 1951 exceeded by almost 17 per cent that of the first five months of 1950.

This gain does not measure up to the 455 per cent gain in military and naval facility construction nor the 321 (public) and 104 (private) per cent gains for industrial construction, but it does dramatize the firm position of health facility construction in a war mobilization economy.

Social, recreational and miscellaneous public and private construction marks were dropping off sharply. Residential building also was slowing down comparatively but still a few percentage points ahead of 1950.

This is the status of public and private hospital and institutional construction as further described in the report:

Hospital and institutional construction expenditures

	Expenditures (in millions)			Expenditures (in millions)		
	May '51	May '50	Per cent change	First 5 mo. '51	First 5 mo. '50	Per cent change
Private	$36	$29	24.1	$163	$134	21.6
Public	$52	$40	30.0	$217	$191	13.6
Total	$88	$69	27.5	$380	$325	16.9

"If haze lifts in near future from complicated picture of material requirements in civilian health and hospital field, large share of credit will belong to American Hospital Association. Granted that Public Health Service is industriously collecting statistical data needed to justify requests for raw materials, it is AHA that is figuratively banging tables to the end that the most favorable action may be taken in the least possible time."
—Washington Report on the Medical Sciences.

part of such building, structure or project.

4. *State departments of health and state Hill-Burton authorities will distribute instruction sheets and application forms.* Late last month, Form CMP 4-C, which will be used, was in the process of being printed by the Government Printing Office.

The division of Civilian Health Requirements (Public Health Service) will send supplies of forms and instructions, when released, to all state hospital survey and construction agencies. They will distribute these forms to all hospitals and construction projects underway or planned, of which they have knowledge. Copies of the forms and instructions also will be available at all NPA field offices and FSA regional offices.

5. *Completed forms should be sent to the Division of Civilian Health Requirements, Public Health Service, Federal Security Agency, Washington 25, D.C.* This is the agency through which hospitals have been receiving assistance for obtaining critical and other hard-to-get materials for construction and day-to-day operations. Assistance for filling out the application form may be received from representatives of state health departments and from NPA officials in the field offices of the U. S. Department of Commerce in most major cities.

HOSPITAL RESPONSIBILITY

Hospitals taking part in this program will, in a large part, determine the effectiveness of the program. Supplies of steel, copper and aluminum to provide for essential hospital and health facility construction have been authorized for delivery in the third quarter of 1951 under the Controlled Materials Plan. These were announced in June in a joint statement by the Defense Production Administration and the Federal Security Agency.

The amounts approved for delivery during the quarter beginning July 1 are as follows:

Carbon steel	75,000 tons
Alloy steel	none
Stainless steel	950,000 pounds
Copper and copper base alloy	4,600,000 pounds
Aluminum	550,000 pounds

The notification of allotment of materials will be accompanied by an authorization for the institutions concerned to use a preference rating in purchasing other materials and equipment (such as boilers, elevators and sterilizers) required for construction.

Where the hospital's responsibility lies is in the judicious use of these critical supplies. "Not all of our hospitals will get all of the materials they want," Surgeon General Leonard A. Scheele said when announcing the allocations. "Essential as new hospital construction is, we must recognize that our needs in this area must be thought of in relationship to the needs of our armed forces and our expanding defense economy.

"Intelligent planning of projects, the postponement of nonessential ones, and the conservation of critical materials (such as the use of reinforced concrete instead of structural steel frames) whenever feasible, should make it possible for this allocation to provide for essential needs in the immediate future."

The weight of responsibility rests with the architect, contractor and hospital authority to conserve critical materials. Applications which do not show signs of such consideration will be brought up for review with the applicant, a Public Health Service representative explained.

USE OF RATINGS

Controlled construction materials and supplies will be allocated directly to the user—the hospital or its contractor. The user will receive notice that he is permitted to use a specified amount of controlled materials.

The so-called rating that he gets is passed along to whatever supplier is to furnish construction materials or equipment installations. Somewhat oversimplified, it might be expressed in this manner:

The National Production Authority, through the Federal Security Agency, will set up a controlled materials credit account of steel, copper and aluminum for the individual hospital which has an approved CMP application. When the hospital's contractor orders critical materials for the hospital he will issue "checks" against that materials credit account. The supplier, in turn, will use the hospital's "checks" to replenish his raw materials stock when he goes back to the mills for more copper, or steel or aluminum. In government terms, that is an extensible rating of the vertical type.

Just as a hospital errs if it overdraws on its cash account in the bank, so will it err if it overdraws on its controlled materials credit account with the National Production Authority. For that reason the hospital is expected to keep records that are open to inspection of the NPA's compliance division.

If the program works according to plans, however, the allocation of definite amounts of these basic materials for use in construction will be of great service to hospital authorities and their contractors. It will enable them to plan with definite assurance that the materials they require will be available at the time needed. And that fact should mean an end to costly work stoppages caused by lack of construction materials.

FRED A. HOFFMAN, elevator starter at California Hospital, shows his hand carved Spanish galleon at the annual hobby show.

Hospital hobby show gains full community support

L. P. CORBETT

THE HOBBY SHOW held recently at the California Hospital in Los Angeles was a pleasing example of self expression by happy people. This annual show originated only a year ago in our nursing department.

Our public relations department wrote a press release for the metropolitan papers which brought two immediate and unforeseen reactions. First, the employees were enthused with the opportunity of displaying the results of their leisure hours, and their applications literally poured in. The nurse and the tray boy, the engineer and the librarian came together to display and share a common interest in ceramic skunks, needlepoint, rug-making, leather tooling, photography, sculpture, painting and collecting.

Secondly, members of the blase press, prepared to "snap and fade" found themselves staying on, taking more pictures and demonstrating a personal as well as professional interest in this glimpse into the private lives of hospital people.

This year the urge for the show was more spontaneous than ever and 67 exhibits were set up in the auditorium with many others rejected because of the lack of space. Originators and participants alike have insisted that no prizes of intrinsic worth are to be awarded; offers of such prizes from staff members and the administration have been turned down. Instead, ribbon awards are presented in four divisions with first, second and third place prizes in each division and a great purple Sweepstakes Ribbon for the judges' choice.

About 700 visitors—employees and patients—swarmed through the one-day exhibit (10 A.M. to 4:00 P.M.) while flash bulbs popped and television cameras transmitted the scene. Hobbies of skill, dexterity and satisfaction were represented, and a tour of the auditorium revealed that hobbies can entertain, look lovely, taste good and be useful.

It was a great day and much praise is due those members of the nursing staff who took part in conceiving, planning and executing one of the most enthusiastically received employee activities ever witnessed here.

WELCOME sign at the hobby show is flanked by cookies made in the dietary department.

A WOMEN'S auxiliary exhibit of rare dolls is examined by Judge Evelyn Shalda and nurse Elizabeth Peirson, originator of the show. This exhibit was featured locally on television.

L. P. Corbett is director of personnel and public relations at the California Hospital, Los Angeles.

EDITORIALS

Courageous and far-seeing

IT HAS BEEN SAID often that Blue Cross plans and hospitals can settle among themselves any disputes that threaten to destroy their partnership relations. This implies that both sides recognize the necessity of self-discipline and that when the occasion calls for it, either side will be equal to the job of disciplining itself.

Had a great many such disputes not been settled heretofore, the partnership would have fallen apart long ago. At one highly sensitive point of contact, however, little progress has been made. This is the point at which a hospital administrator, or one of his employees, is free to exercise judgment in billing the Blue Cross plan.

Without doubt every plan can find in its records numerous examples of charges which the plan can view only as excessive. Of course the fact must be faced that a plan always wishes its bills could be lower, and a hospital always wishes its plan payments could be higher, and that the day probably never will come when there is not room for an honest difference of opinion.

But the examples of excessive charges are something else. The plan's records are likely to show, also, that certain hospitals turn in the most unreasonable bills and do so persistently. Somebody in each of those hospitals obviously is too much absorbed in his own office problems and so has lost sight of an important goal.

It takes little imagination to see what would happen to Blue Cross if every hospital administrator felt free to gouge the plan that serves his hospital. Either the patient benefits must come down or the cost of protection must go up, until Blue Cross is no longer able to serve the public—and voluntary hospitals will then be up for grabs.

The question is: What can be done? Where does self-discipline come in, and who is to see that it is exercised? Because this is a widespread problem, and because the time for solving it is short, a decision reached by the Maritime Hospital Association is significant.

As reported in the news section of this journal, members of that association, which covers three provinces in eastern Canada and Newfoundland, have set up the machinery for policing themselves. They have (a) formally invited the Maritime Hospital Service Association (Blue Cross) to report any "exorbitant charges or other abuses" on the part of a member hospital, and (b) in the absence of remedial action, recommended cancellation of the Blue Cross contract with that hospital. Meantime, the hospital association has appointed a committee which will try to bring about the remedial action necessary to avoid cancellation.

This is a courageous and far-seeing decision. With no illusions about the difficulties involved, members of the Maritime Hospital Association are accepting an unpleasant responsibility which may have to be accepted by other hospital organizations if hospitals and Blue Cross plans are to hold their partnership intact.

In search of equity

IN ALL PROBABILITY the recent Conference on Method and Amount of Hospital Payment has opened a path that eventually will lead through the woods.

For several years it has been evident that the day would come when voluntary hospitals must find a safe and fair basis for dealing with third-party purchasers of hospital service.

These third-party agencies have grown in number and variety, the proportion of service thus purchased has grown in volume, and the issues have grown in complexity until it has become all but impossible to determine where the equities really lie.

As described on pages 37-39, the recent conference brought together some 70 persons representing both the buyers and sellers of hospital service. For three full days they discussed, in good humor and frankness, the issues and equities and conflicting responsibilities.

It was not the purpose of this meeting to produce official pronouncements of policy. Rather it was anticipated that a body of data and philosophy, drawn from the experiences and viewpoints of people who work continuously with the problems of dispensing and purchasing hospital service, might be assembled for use by local groups as the basis of their own policy discussions.

A full record of these discussions is now in the process of being edited, and summaries will be distributed for study and comment by state hospital associations and other interested organizations. It is intended that all hospital administrators will have the opportunity—and responsibility—to help to develop that safe and fair formula which is the object of this search.

A bit of misguided zeal

URGING RECRUITMENT OF students for schools of nursing accredited by the nursing organizations can greatly handicap enrolment of the number of young women who should be admitted to nursing schools this year.

An Ohio administrator discovers that a nursing organization has been at pains to bring the principals of all nearby high schools up to date on which schools of nursing are accredited and which are not. High school principals are not likely to be familiar with the entangled issues of nursing school accreditation, nor to realize that many schools not yet acceptable to the league are fully approved and licensed by their state governments.

Thus confused, small town high school principals can scarcely urge their students to enroll in the nearby *unapproved* schools of nursing, and many potentially good bedside nurses will be lost because they have neither the money nor the courage to seek a nursing education in some distant city.

In reporting this example of misguided zeal, the administrator makes a point with which everyone agrees: That many hospital schools of nursing are in need of improvement, that the school accreditators program is right in principle, that the goal can be reached with a reasonable amount of patience and tact; but it will not speed the day of victory to choke out all small schools that cannot clear the hurdles fast, and certainly any attempt to do so at this time is a disservice.

It would be hard to improve on the Ohio administrator's further observation. He asks what would have been accomplished by the American College of Surgeons, had it launched its standardization program many years ago by sending word into the community of each substandard hospital, informing the citizens that their hospital was unfit for college approval—instead of working patiently and sympathetically to raise standards.

Accreditation

WHETHER THE PROPOSED joint program of hospital accreditation materializes now depends on a vote by the House of Delegates of the American Hospital Association when it convenes in St. Louis next September. This proposal has been endorsed by the American College of Surgeons, the American College of Physicians and the American Medical Association—the latter in Atlantic City last month.

If the American Hospital Association adds its approval, the assignment thus jointly undertaken will have a potential that is limitless. Its possibilities reach far beyond a continuation of the American College of Surgeons approval program, valuable as that has been.

For the first time, voluntary organizations representing medical care and hospital care would be able to pool their resources and initiative, to plan and pull together—the ultimate in voluntary effort to promote better health.

Such an effort will succeed, of course, only if each organization keeps its eye on the goal and gives as well as takes in the division of labor and the sharing of responsibility. Those who have put the proposal together during a year of discussion are agreed that such a spirit has been developed up to this point, and they believe it can be carried over into the working program.

To avoid trouble

WHILE IT IS hardly customary for hospitals to boost an operating expense as a matter of policy, today's circumstances suggest that such a policy may very well represent prudent administration. The expense item is payroll, and its relation to prudent administration becomes evident on looking back at some recent history.

World War II was not very old before good hospital employees began to drop from sight. Since this was a new experience, many administrators and their boards waited until their most valued employees had been hired away by industry before seriously considering a revision of their wage programs. Then it was necessary to hunt desperately for anyone who could be hired. Many of these replacements were incompetent and the turnover was high. Frequently the salaries paid, had they been offered earlier, would have averted the original exodus of highly competent personnel.

Now, less than 10 years later, the evils of inflation are abroad once more. Government controls already in effect and those planned may lessen the squeeze, but certainly there is a real danger that hospitals will find themselves in trouble again unless they look ahead.

Hospitals today have some added resources as they face the threat of severe personnel shortages. Not only may they call on World War II experiences for general guidance, but a good deal has been learned about adapting scientific personnel management techniques to the hospital organization.

Even without the pressures of a national emergency, most hospitals would find it impossible to keep their service up to standard without some part of an up-to-date personnel program. All employees nowadays expect old age pensions, with federal social security benefits as a minimum. Many will readily trade their familiar surroundings for the systematic approach to recognizing merit, assuring promotions when earned, and hearing grievances. When only a slightly higher pay rate is added to these items, temptation to depart for a new job is very great.

Such are the circumstances that suggest some policy planning that will increase operating expenses. No matter what other problems the emergency has in store for hospitals, they can be better endured if the administrator has a nucleus of competent and reasonably contented persons in the key jobs.

What MINIMUM STANDARDS mean

to the hospital pharmacy

SISTER M. ETHELDREDA

STANDARDS FOR the administration of the pharmacy department are necessary for the attainment of a high quality of service and good management. Last year the American Pharmaceutical Association's Division of Hospital Pharmacy adopted the "Minimum Standard for Pharmacies in Hospitals" in order to detail the minimum requirements that must exist in a hospital pharmacy which offers quality service.

The new standard has been adopted by the American Hospital Association and other allied organizations.

Application of the standard should result in more efficient departmental administration, speed up the filling of orders and reduce the possibility of error. Good management usually is a corollary to the quality of service offered by the pharmacy.

The "Minimum Standard for Pharmacies in Hospitals" has six major points — organization, policies, personnel, facilities, responsibilities, and the pharmacy and therapeutics committee. It is directed toward the chief pharmacist of the average hospital pharmacy, under whose management the new standard may be given practical application.

ORGANIZATION

A hospital pharmacy is a professional service unit, serving the inpatient, professional staff, lay personnel, administration and outpatient. It should be directed by a professionally competent person. To insure continuous and efficient service, there must be a systematic organization in the department. An outline of departmental functions and a program of daily routine are imperative for each unit.

Sister M. Etheldreda is chief pharmacist, The St. Mary's Hospital of the City of Brooklyn, N. Y. Adapted from a paper presented at the convention of the Ontario Hospital Association, Toronto, October 1950.

An analysis of pharmacy service in the hospital shows four separate and distinct functions:

- Dispensing to hospital units involves replenishing of routine stock, dispensing and compounding special orders for individual patients, and filling orders for specialty departments.

Much of the work in this unit may be facilitated by the prepackaging of medicinals. Allowance must be made for a certain amount of extemporaneous dispensing of prescriptions. In a busy hospital, filling special orders may be a full-time job.

- Dispensing to outpatients also may be simplified by the prepackaging of supplies.
- Manufacturing of sterile and nonsterile pharmaceuticals: In order to provide medicinals promptly and economically without the sacrifice of quality, the pharmacist must always anticipate a physician's requests. This anticipation and preparation of supplies comprises the manufacturing program of the department. Bulk preparation of ointments, internal and external liquids, mixtures, emulsions, lotions, suppositories, powders and capsules should be carried on continuously.
- Administration covers such procedures as purchasing and accounting, keeping of narcotic and other legally essential records, inventory controls, preparation of periodic and annual reports, and implementing the administrative, professional and personnel policies of the department.

POLICIES

There are two types of policies a hospital pharmacist must outline: (1) Administrative policies, some of which may have to be prepared with the cooperation of the administrator, and (2) professional policies approved and prepared with the pharmacy and therapeutics committee.

Administrative policies include rules and regulations directed to the nursing personnel. A guide book stating common procedures in the ordering and handling of medicinals may eliminate many misunderstandings and aid interdepartmental relations.

Rules, once established, must be reviewed periodically. New procedures may be necessitated by the introduction of a new drug or a change in technique. When changes are effected, the nursing department must be informed.

Other policies must be set on the number of pharmacists and other employees in the department, hours of work, how much manufacturing will be done, the filling of outpatient prescriptions, duties of the chief pharmacist, and general personnel policies.

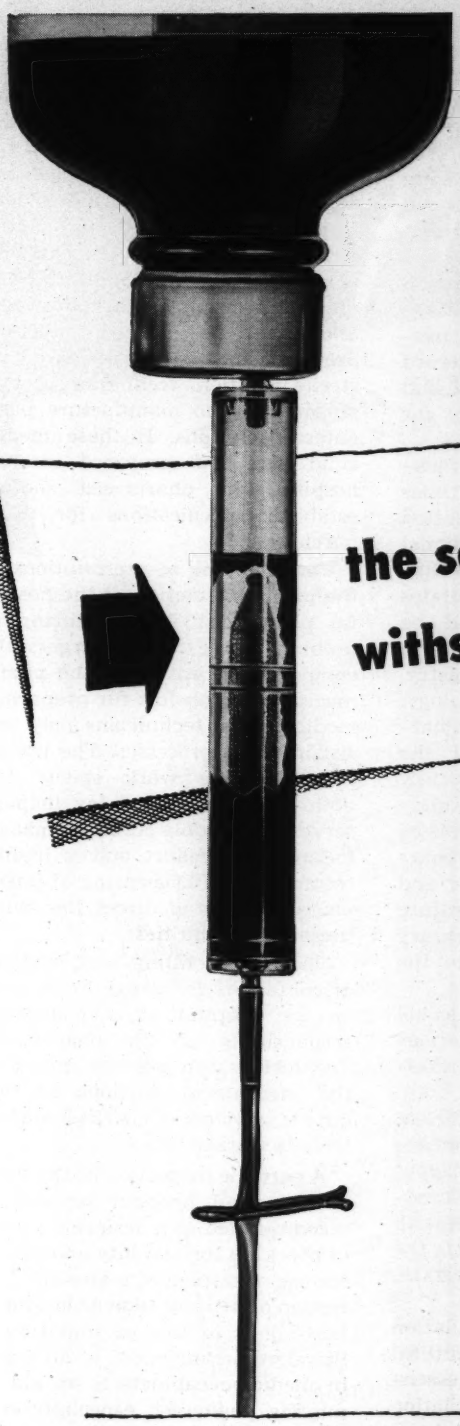
Policies pertaining to the professional operation of the department, prepared with the cooperation of the therapeutics committee, are discussed below.

PERSONNEL

To determine the number of employees required in a hospital pharmacy, one must consider the type of hospital, bed capacity and extent of activity in the department. Attempts to set a ratio of pharmacists to bed capacity have not resulted in any general standard of personnel requirements.

More important than the number of employees are their qualifications, fitness and ability to do the work expected of them. All pharmacists must be graduates of approved schools of pharmacy and registered by the state in which they are employed. The chief pharmacist should have a bachelor of science degree and at least one year hospital pharmacy experience.

All registered pharmacists in



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hospitals should be active members of the professional organizations, the American Pharmaceutical Association and the American Society of Hospital Pharmacists.

A hospital pharmacy internship is advocated for all prospective hospital pharmacists. Many aspects of hospital pharmacy may be mastered only through practical experience, personal observation and individual instruction. Internships are the equivalent of specialty training.

Job analyses and schedule manuals based on a prescribed time order help produce better service and smooth functioning. It is important to present to any employee a list of the responsibilities he is to assume. It is equally important to help the beginner, the slow-thinking or forgetful person by giving him an exact time and schedule manual to follow for a period of a week or a month.

It is a good policy to alternate duties and rotate services so that one employee does not always have to perform the same functions. Doing the same thing continuously becomes monotonous and is followed by a lack of interest, boredom and restlessness. Monopolized jobs also create problems for the chief pharmacist when, either temporarily or permanently, he must find a replacement.

FACILITIES

Equipment for compounding, dispensing and manufacturing must meet the requirements of state boards or other agencies regulating the practice of pharmacy. Equipment requirements depend on the volume of manufacturing done. Manufacturing, in turn, should be related to economic factors, available personnel and physical facilities. Manufacturing for the sake of manufacturing is not a good policy. It is not advisable to prepare potent tinctures which require a biological assay in the average hospital pharmacy. Nor should the average pharmacy be expected to manufacture tablets.

Whether or not a hospital pharmacist will maintain a sterile solution laboratory again depends upon administrative policy. Proper equipment and apparatus are desirable for an adequate setup. A separate room equipped with dust-stops; ultraviolet light; dust-free hoods; specialized equipment, such as water stills, autoclaves, bacteriological filters and vacuum pumps, is essential. Even if sterile products are not manufactured in bulk, a hospital pharmacy should be equipped to produce small volume, multiple-dose sterile preparations.

Bookkeeping supplies and record forms are required for coordinated service. These include printed requisitions, prescription blanks, narcotic record forms, purchase record forms and orders, price lists, and other intradepartmental forms for control.

A pharmaceutical library is mandatory. It should have at all times the latest editions of the "United States Pharmacopeia," "National Formulary," "New and Non-Official Remedies" and "United States Dispensatory." There should be textbooks and reference works in the fields of pharmacy, chemistry, pharmacology and bacteriology. Publications of the American Pharmaceutical Association, and the journals of the American Society of Hospital Pharmacists and American Medical Association should be available. House organs of pharmaceutical firms, brochures and other forms of current literature should be accessible. This library should be made available to the medical staff.

By law, narcotics and alcohol must be kept in locked storage. Adequate refrigeration for thermolabile drugs is essential.

Floor space should be sufficient to carry on the work of the department. Floor plans and layout may be guided by suggested standards of the U. S. Public Health Service. (See "Elements of the Hospital Pharmacy," HOSPITALS, October 1950.)

Proper lighting and ventilation are equally important for healthful and safe working. Light is essential to accuracy; proper ventilation is required in the handling of potentially explosive and inflammable drugs.

RESPONSIBILITIES

The position of chief pharmacist carries with it the responsibility and authority to execute many functions.

The preparation and sterilization of injectible medication when manufactured in the hospital is the responsibility of the pharmacist. Parenteral medications are in reality drugs, therefore the preparation of these medicinals should be under the control of the pharmacy department and should not be assigned to unqualified and unlicensed personnel. Sterile technique is a refinement technique which not every hospital pharmacist can undertake. The pharmacist must be prepared and well experienced in sterile solution technique if the pharmacy is to manufacture parenteral solutions. If these medicinals are not prepared in the hospital, the pharmacist should establish specifications for their purchase.

Compounding of prescriptions is the primary function of the hospital pharmacist. Manufacturing is nothing more than large-scale compounding. Although the pharmacist is responsible for preparing medicaments, technicians may assist in many processes. The use of comprehensive work sheets for both professional and lay helpers serves as a double check on manufacturing procedure and is highly recommended. Dispensing of pharmaceuticals is in direct line with these responsibilities.

The proper filling and labeling of containers for drugs to be used on the hospital units is another responsibilty of the pharmacist. Technicians can perform much of the mechanical portions of this duty if a system of checks and controls is worked out.

A periodic inspection of the drug units on all hospital services is recommended as a desirable means of checking the stability and fitness for use of dispensed materials. Detection of deterioration or improper labeling is of utmost importance. Standard arrangement of all drugs in medicine cabinets is an aid to nursing personnel, especially student nurses.

A well stocked emergency suite, antidote list and methods of treating poisoning should be available for use when the pharmacy is closed. An arrangement with the nursing school office is recommended in this connection.

The dispensing of narcotics and alcohol and the keeping of records

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to meet legal requirements are duties of the hospital pharmacist. Locked compartments for storage, accurate and easily traced records and a perpetual inventory of these items are required. When other dangerous drugs are covered by legal regulatory action, the pharmacist must see that these requirements are fulfilled.

Specifying quality and source of medicinals used in the treatment of patients is a major function of the hospital pharmacist. Accurate, precise specifications are necessary. The pharmacist who is thoroughly familiar with the channels of distribution should purchase these supplies to save time and reduce the possibility of error. When the central purchasing department buys for the hospital, an agreement should be reached by the purchasing agent and pharmacist based on respect for the duties of each. Specifications may require that exceptions be made to general principles of the hospital's purchasing policy. In some purchasing problems, the pharmacy and therapeutics committee may have to be consulted.

Hospitals today are operated on a business basis. As in all business ventures, records and accounting methods are criteria of proper organization and internal control. The bookkeeping setup for the pharmacy should be determined by the accountant and the administrator.

Teaching student nurses and cooperating in the medical intern training program are other professional obligations of the pharmacist. These educational duties may be direct or indirect. In the nursing school, the pharmacist may serve as instructor of pharmacology if he possesses the qualifications of a good instructor. Professional teachers frequently are preferred to a specialist for the instruction of student nurses. In addition to teaching, the pharmacist may supervise student nurses in the planning of conferences, seminars and panel discussions on therapeutic agents. Other indirect methods of instruction include the preparation of samples to be used as visual aids.

Participation in the medical intern program usually is restricted to informal discussion of drug products and their use or action. Scheduled lectures are infrequent but a few are advisable to orient new interns.

State and federal laws and government regulations as they affect the hospital should be emphasized. Concerning the Harrison Narcotic Act, interns appreciate information about the stamp, method of purchasing narcotics and the inventory required of a medical practitioner.

A few model prescriptions may teach an intern more about prescription writing than any amount of theoretical drilling, especially in a hospital with a good formulary in use.

Implementation of decisions of the pharmacy and therapeutics committee is a professional obligation of the pharmacist. A good means of informing the medical staff of action taken by the committee is a bulletin or newsletter, published as an aid in announcing products added to the formulary, new rules and changed procedures.

Periodic reports to the administrator familiarize him with departmental operations and may serve to stimulate interest in the pharmacy. Statistical reports show the extent of activity in the department.

PHARMACY COMMITTEE

The importance of a pharmacy and therapeutics committee is evident by its requirement as a part of the minimum standard.

Committee members are chosen from the medical staff. The chairman is usually the director of medicine. The chief pharmacist acts as secretary and transmits the proceedings of the group to the proper governing bodies.

The committee advises on matters concerning the pharmacy and pharmaceutical services in the hospital. Its primary duty is to develop or adopt a formulary of approved drugs for use in the hospital. Standardization in a formulary, however, should not be too stringent. Once established, the formulary should be kept current and in circulation. A procedure whereby staff members may submit requests for additions to the formulary must be defined. Suggested products should be evaluated on the basis of clinical data.

The committee may help the pharmacist avoid the stocking of duplicate brands of material, and it may recommend items to be carried on the nursing units.

At least two meetings of the pharmacy and therapeutics committee should be scheduled each year. One of the most successful methods of arousing the interest of the committee is to prepare a comprehensive, worthwhile agenda and mail it to the members before each meeting. If meetings are marked by the absence of key members, it is advisable to hold fewer meetings and call them as the occasion may require. It may be desirable to permit interim decisions on matters pertaining to a particular medical service by the committee representative of that service, rather than call a meeting of the entire group. Interim decisions then may be approved at a subsequent meeting.

Policies on the restriction and controlled use of scarce items or expensive new drugs for routine use must be formulated by this group. The use in the hospital of unmerited drugs should be forbidden as part of the policy.

The effectiveness of the pharmacy and therapeutics committee can best be evaluated by the attitude of staff members toward its decisions. Much of the committee's success depends on the initiative of the pharmacist and his willingness to carry out these decisions. The committee is the link that connects the professional staff, the pharmacist and the administrator. Its resolutions should carry the prestige of a regulation and should be accepted as such.

In this portrayal of a hospital pharmacy that would meet the minimum standard, all hospital pharmacies have not been cast into the same mold. Allowances must be made for various types and sizes of institutions. It is possible, however, without unusual qualifications or unattainable facilities, to establish a coherent functional unit. We must expect temporary interference with the attainment of this goal, and in some instances the task may appear tremendous; but with persevering labor and a vigorous determined approach we can meet these requirements.

Ingenuity and testing help in buying housekeeping supplies

STELLA GRAHAM

THE PURCHASE of housekeeping equipment and supplies directly and indirectly affects patient care and its cost.

The primary aim of Baptist Memorial Hospital and of every hospital is to render the best of total care to the patient at the most reasonable prices possible.

The housekeeper shares in this responsibility through the quantity and quality of supplies requested and through the efficient workmanship demanded of employees in the department. Ultimately the patient is the recipient of good care or poor care, efficiency or inefficiency, high cost or reasonable cost, clean or unclean surroundings—all of which affect his recovery and all of which must be paid for by the patient.

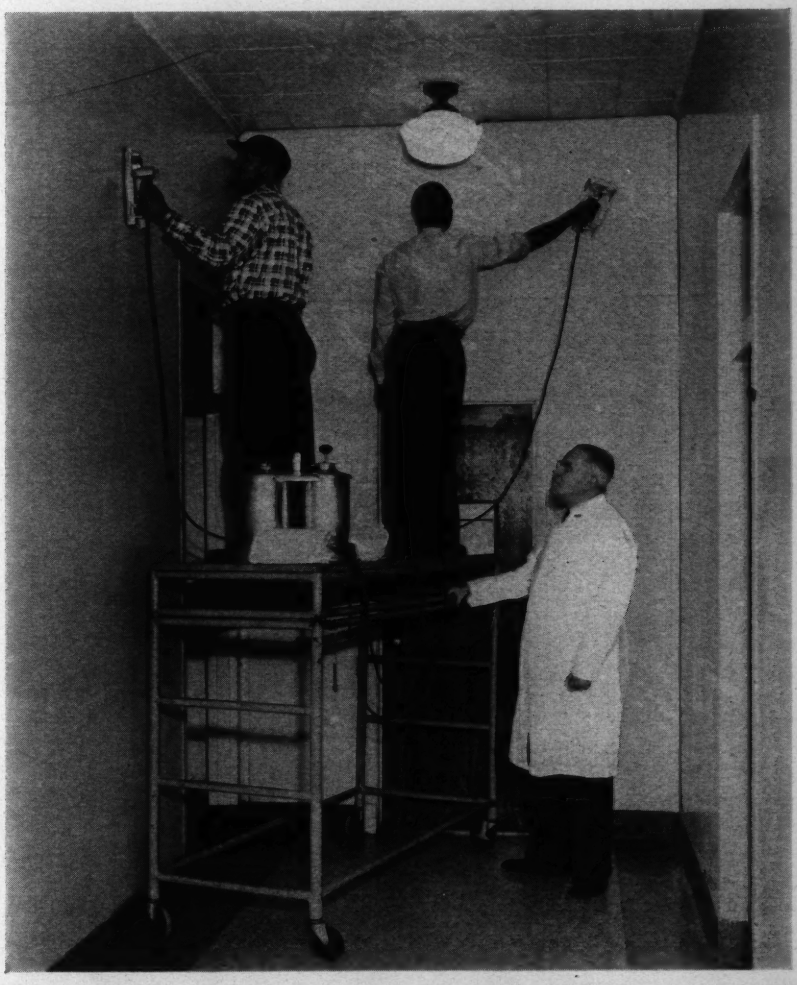
At our hospital, we have found ways to keep this cost down.

For many years of routine wall washing we used two step ladders with a plank between them serving as a platform. We used two pails, one containing the cleaning fluid and the other containing the rinse water. Throughout the day, numerous trips were necessary to replenish the detergent supply, to empty dirty water and secure a fresh supply and to obtain additional rags. After scrubbing the floor to remove the spillage, we considered the job complete. After a 30-day test, however, we became convinced that a better, quicker, cleaner, more economical job could be done with the proper wall washing machine.

At present we are using two wall-washing machines. Tests have proved that two men using this machine can wash and rinse approximately 4,500 square feet of wall space in an eight-hour shift. This is done on one filling of the chemical tank at a cost of six cents. If the walls are extremely dirty, the price per day per machine increases to 12 cents.

We have found that under the old system of wall washing, two wall washers used an average of 12 pounds of detergent at a cost of seven cents per pound, making a total daily cost of 84 cents as compared to the six cents or 12 cents using the new system. The wall washers, under the old system, washed between 2,500 and 3,000 square feet of wall space per day.

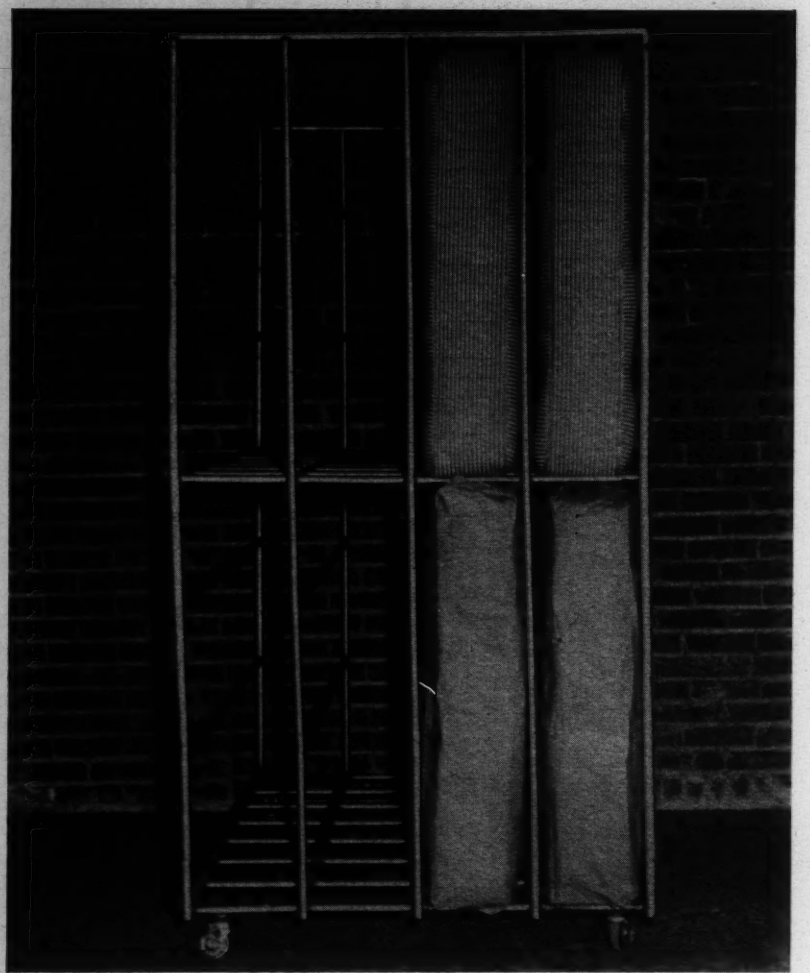
Having two men operating each machine seems to be more economical, as one man can do the washing and the other the rinsing.



WALL-WASHING machine enables two men to wash and rinse about 4,500 square feet of wall space in one day. The machine is mounted on a rolling platform, with five-inch locking casters, which was designed by the housekeeper and built by the maintenance department.

Miss Graham is executive housekeeper of the Baptist Memorial Hospital, Memphis, Tenn. Adapted from a paper presented before the American Hospital Association's Institute on Hospital Purchasing, St. Petersburg, Fla., April 1951.

CONVENIENT mopping unit (above) was designed by the housekeeper and built by the engineering and maintenance department. It holds all the maid needs to finish cleaning rooms.



INNERSPRING mattresses are stored in this special rack, also designed and built right in the hospital. The rack holds eight mattresses on edge to prevent sagging of springs.

It eliminates the necessity of scrubbing the floors as was necessary under the old system. If needed, an additional trowel is available to dry the wall. This method of wall washing eliminates the wasted time involved in the old method and saves labor.

An additional feature of the wall-washing machine is the movable platform. The housekeeper designed this platform, and it was constructed by the maintenance and engineering department. It is 27 by 72 by 54 inches, not extended. An extension feature gives it a total height of 68 inches. The entire platform is mounted on five-inch casters which can be firmly locked.

Through experience we have found that the average commercial-type mopping units offered us have not been as satisfactory and as economical as the unit designed by the housekeeper. This unit, constructed by the maintenance and engineering department, consists of a carriage mounted on 2-inch casters that carries two 10-quart pails —one holding the cleaning solution, the other containing the rinse water. It has a squeeze type wringer with a capacity of a 16-ounce hand mop. The carriage holds a dustpan, a radiator brush and a gum scraper, giving the maid all the necessary equipment to complete her room cleaning.

Floor machines comprise the other type of equipment used in our housekeeping department. These are 16-inch standard-type rotary models with *both* the scrubbing and polishing brushes interchangeable. These machines are operated by a porter trained primarily in the cleaning of halls and lobby.

In the use of these machines, we have discovered that a steel wire brush will outwear approximately three fiber-type scrubbing brushes. In addition, the steel wire brush will do a more thorough and faster job of cleaning, particularly on terrazzo floors. We have found also that a steel wool pad for polishing will do an excellent job, but we question the economy of this type of material over the bristle brush. By purchasing brushes without the metal plate and transferring the metal plate from the worn-out brush to the new brush, we have

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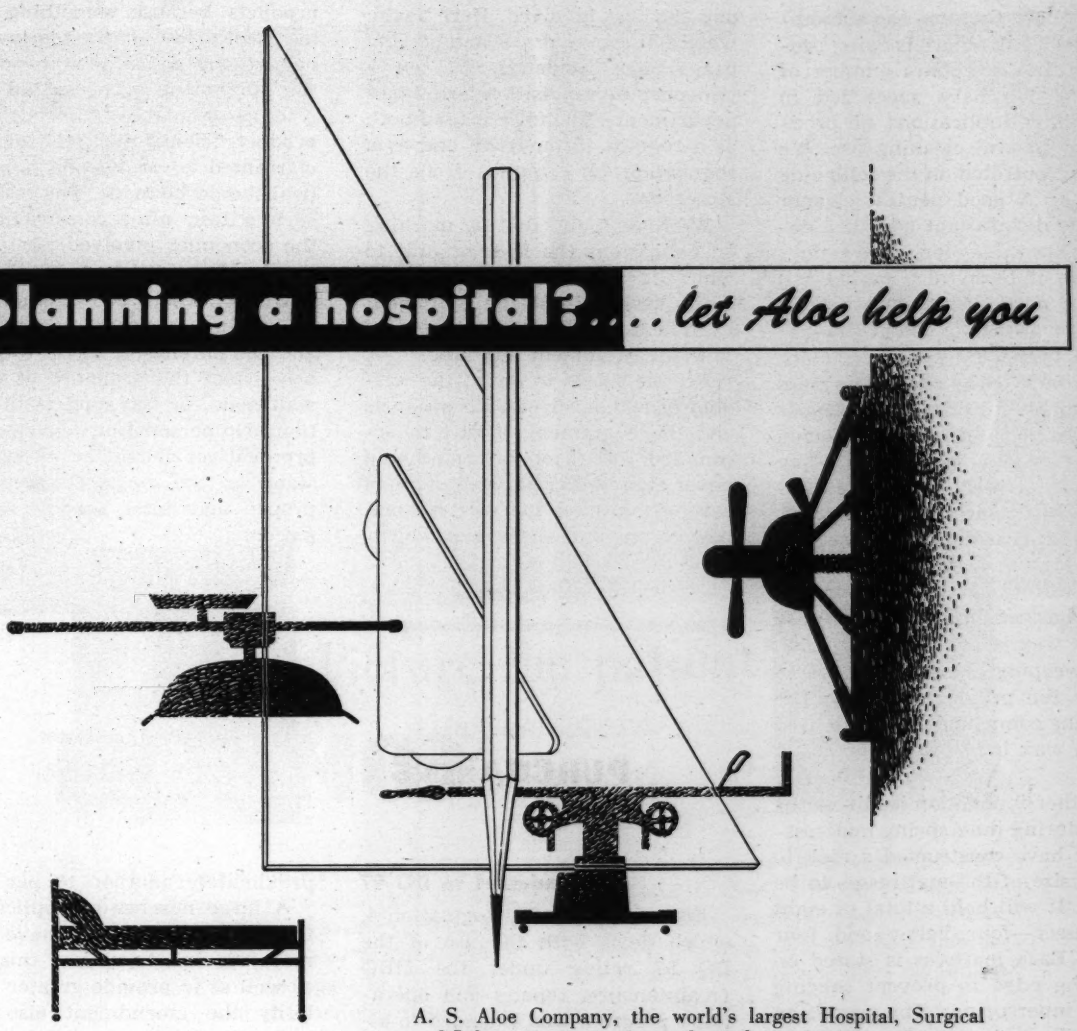

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After tests with several products, we are now using on our terrazzo and asphalt tile floors a cleaner with disinfectant already added and the original cost is less than what we formerly paid for a neutral cleaner, without disinfectant. This product is doing a very satisfactory job at a minimum of cost. Again, testing cannot be too strongly emphasized. It is the only satisfactory way to evaluate a product.

A sweeping compound helps to relieve the problem of dust. The sweeping compound should be used with a wax base instead of an oil base.

Another innovation is our method of storing innerspring mattresses. We have constructed a rack to fit the size of the mattresses to be stored. It will hold a total of eight mattresses—four below and four above. Each mattress is stored on the long edge to prevent sagging of the innersprings. The rounds on which the mattress rests were constructed in such a way that it will roll, making it easier to place the mattress in the rack and to withdraw it when ready for use. The whole rack is mounted on four-inch casters so that the racks can be easily moved for proper cleaning of the floor.

Housekeeping supplies are kept in central stores. Requisitions are issued by the department head or by the assistant housekeepers. Even though a perpetual inventory is kept by the storekeeper, a final inventory is made during the month by the housekeeper as a further check on the daily usage of the various supplies and for a monthly cost analysis. The housekeeper gives the administrator a monthly report, the same as the accountant and the purchasing agent do. Monthly comparisons can be made as to the amount of supplies used and the cost involved. Here again, watchfulness over economy and usage pays dividends. We use a two-purpose requisition form in all departments. The form is used both as a request to purchase and as a requisition for supplies from the storeroom.

We have found that by marking on equipment the floor or unit to which it is issued, we can more easily keep up with the equipment itself and check on the period of time the equipment will last.

No one seems to doubt the wisdom of standardizing the products and the equipment needed to accomplish a good job, but one should never standardize to the extent of closing his mind to new methods, new equipment, and new products. Neither does he want to be constantly changing methods and products because something new has been placed on the market. We believe the department head and the purchasing agent should analyze as best they can any new product. Then if they feel that it is warranted, a careful and unbiased trial should be made. The result of such a test, after considering all the economies involved, should be the deciding factor.

We believe in coordination and cooperation between departments and the purchasing agent to properly effect the economy of a job well done for the good of the patient. No personal or departmental prerogatives should be allowed to stand in the way of giving the proper and total service to the patient.

PURCHASING COMMENT

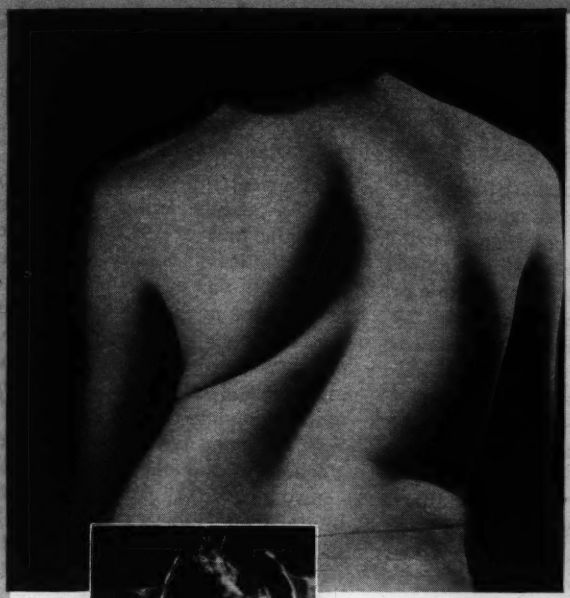
Amendment to DO 97

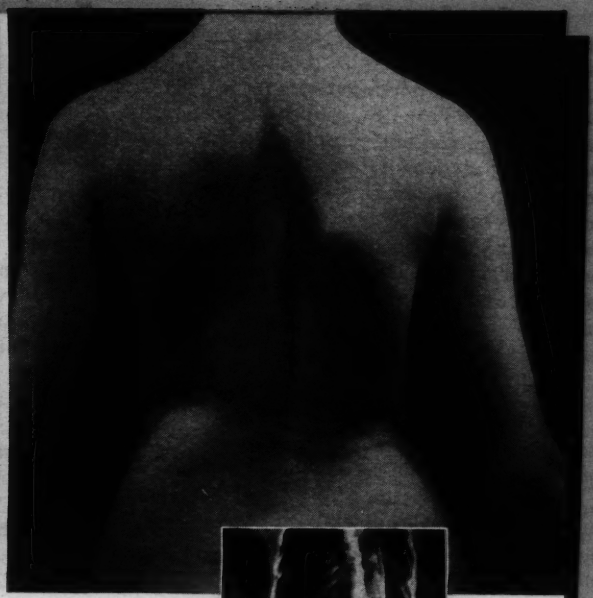
EFFECTIVE May 22, Regulation 4, which deals with the use of the DO 97 rating under the MRO (maintenance, repairs and operation) program was amended to allow its more extensive use, and at the same time greater flexibility. Previously, expenditures for purposes of MRO were limited to 100 per cent of such expenditures during the previous year, unless application for an increased quota was made. The amendment permits use of the DO 97 rating up to 120 per cent of the previous year's outlay. This is intended to compensate for increased prices and greater utilization of facilities. It is estimated that prices have increased by approximately 10 per cent and that increased demand accounts for approximately another 10 per cent.

A large number of applications for quota adjustments have been received, and to reduce this flow as well as to provide greater flexibility the amendment also provides that the use of DO 97 for certain purchases no longer automatically requires that all MRO expenditures be charged against the quota. As long as rated purchases amount to 20 per cent or less of the quarterly quota, an unlimited amount of MRO items may be purchased without use of the rating. There are certain limitations to the amount of inventory that can be carried and some other restrictions under NPA orders apply to industry and under ordinary circumstances are of no concern to hospitals.

As the order now reads DO 97 may be used for the purchase of scarce items and increased purchases of other items may be made on the open market. Purchase of capital equipment is still limited to $750 or 10 per cent of the quar-

The Purchasing department is edited by Leonard P. Goudy, purchasing specialist.





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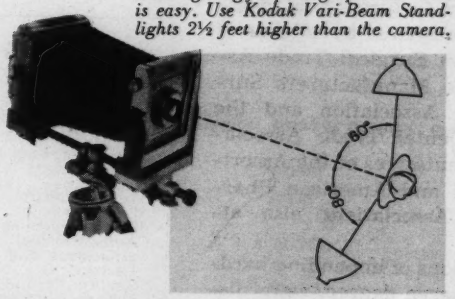

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terly quota whichever is the higher.

Group Purchasing

In North Carolina legislation has been introduced, but not yet adopted, that would authorize charitable nonprofit hospitals to purchase hospital supplies and equipment under contracts negotiated and entered into by the state agency that purchases for state institutions. This seems to be the first time that such an arrangement has been attempted and an effort will be made to obtain up-to-date information as developments occur.

Supply problems discussed

The Association's interest in the welfare of hospitals was made evident again in June at a meeting it called to discuss the problems of supply for civilian hospitals in the face of heavy buying for military purposes. John H. Hayes, chairman of the Association's Council on Government Relations, presided.

This conference was a follow up to the Association's recommendation of last January that the federal government establish some sort of central agency to adjudicate the needs of the several groups represented by claimant agencies.

The Association invited representatives of the Department of Defense, Army, Navy, Air Force, Public Health Service and Veterans Administration to a round table discussion with executives from the Defense Production Administration, National Production Authority and the Bureau of the Budget. Manufacturers and dealers were represented by officials of the American Surgical Trade Association, the Manufacturers Surgical Trade Association and the American Dental Trade Association. Representatives of the American Medical and American Pharmaceutical Associations also attended.

Premonitions of impending hardships, to a large degree, were dispelled as the federal government's claimant agencies revealed plans for long term phased buying and careful exercise of priorities.

Announcements of coordinated "claiming" and additional assistance to hospitals and manufacturers are expected to develop rapidly as results of the conference. —L.P.G.

Current price trends

ALTHOUGH THE increase was very small, the purchasing power of the dollar went up during April. Weekly index numbers, as shown in Table 1 below, with a single exception, were lower on May 29 than at the beginning of the month.

In order to find out how the nation's economists and businessmen view the present slight decline of prices, the Bureau of Labor Statistics early in June conducted an informal poll of these specialists. A majority of the group believe prices will move steadily upward in the fall, except where government price ceilings are in control, with a strong inflationary push after the first of 1952 when much of the military expansion program will have passed from the blueprint to the production stage. Until the fall, the economists predict that the seasonal lull in retail purchasing may force down some commodity prices.

Price wars last month in New York City and other parts of the country affected only 5 per cent of the trade-marked goods sold in department stores and carry little economic significance.

TABLE 1—WEEKLY INDEX NUMBERS

of Wholesale Prices—1926=100

COMMODITY	May 23 1950	May 30 1950	May 1 1951	May 8 1951	May 15 1951	May 22 1951	May 29 1951	% of change 5-30-50 to 5-29-51	% of change 1-2-51 to 5-29-51
All commodities	156.1	156.8	183.4	182.8	182.2	182.4	182.5	+16.4	+3.2
Farm products	165.3	167.5	201.1	198.1	197.1	198.1	199.8	+19.3	+5.5
All foods	160.7	161.5	188.6	188.8	187.7	187.3	188.4	+16.7	+3.6
Textile products	135.6	135.6	183.6	183.4	183.3	183.3	182.9	+34.9	+6.1
Fuel and lighting materials	132.8	132.9	138.3	138.4	138.4	138.5	138.5	+ 4.2	+1.8
Metals and metal products	171.0	171.3	189.6	189.6	189.5	189.5	189.4	+10.6	+1.1
Building materials	198.5	199.6	227.5	227.5	227.4	227.4	227.3	+13.9	+2.2

This weekly wholesale price index is designed as a weekly counterpart of the monthly wholesale price index. It is based on a sample of about one-eighth of the commodities in the comprehensive sample and therefore should be regarded as an indicator of price trends rather than as a final compilation. The monthly index should be used for fuller coverage.

Source: Bureau of Labor Statistics.

TABLE 2—MONTHLY INDEX NUMBERS

of Wholesale Prices—1926=100

COMMODITY	April 1941	April 1943	April 1945	April 1947	April 1949	April 1950	Mar. 1951	April 1951
All commodities	83.2	103.7	105.7	148.0	156.9	152.9	184.0	183.5
Farm products	74.4	123.9	129.0	176.9	170.5	159.3	203.8	202.6
Foods	77.9	108.4	105.8	162.4	162.9	155.3	186.6	185.7
Textile products	81.0	97.4	99.6	140.3	142.2	136.4	183.2	182.9
Cotton goods	86.8	112.6	119.7	197.3	176.2	172.8	239.9	236.2
Fuel and lighting materials	72.9	80.6	83.5	103.2	132.0	131.2	138.6	138.1
Anthracite coal	80.9	89.8	95.3	113.9	135.0	142.6	156.1	152.8
Bituminous coal	100.0	115.6	120.6	145.3	190.7	193.4	197.1	195.4
Electricity	69.2	60.2	58.7	64.3	67.9	67.8	*	*
Gas	78.1	76.4	77.0	84.0	92.3	86.8	93.8	*
Building materials	100.1	110.3	117.1	178.1	196.5	194.8	228.5	228.5
Brick and tile	91.7	98.7	110.6	134.5	160.8	163.4	180.8	180.8
Cement	91.0	94.2	99.4	114.0	134.3	134.9	147.1	147.1
Lumber	116.7	136.8	154.4	273.6	290.6	299.4	361.2	361.0
Paint and paint materials	88.7	102.5	106.3	170.4	157.9	136.7	164.4	164.7
Plumbing and heating materials	83.0	90.4	92.4	117.3	154.9	154.7	183.7	183.7
Structural steel	107.3	107.3	107.3	127.7	178.8	191.6	204.3	204.3
Other building materials	95.9	101.6	103.8	144.4	173.8	172.0	198.2	198.3
Drugs and pharmaceutical materials	97.5	106.1	106.8	181.0	123.0	122.0	185.1	184.5
Raw materials	77.5	112.8	116.8	160.1	165.8	162.5	199.4	197.7
Semi-manufactured articles	85.1	93.1	95.0	147.5	153.1	143.9	187.5	186.9
Manufactured products	85.5	100.6	101.8	142.1	153.0	149.4	175.8	175.9
Purchasing power of the dollar	$1.201	$.964	$.946	$.675	$.650	$.654	$.543	$.545

**Figures not available at press time.*
Source: Bureau of Labor Statistics.

Four methods of adding service value to the hospital laundry

RICHARD L. JOHNSON

NEW SERVICES for the hospital laundry to undertake are a challenge to the alert laundry manager—a challenge that he should not ignore.

In addition to increased benefits to the hospital, assumption of new duties within the laundry make the work more interesting, due to a greater diversity of tasks.

There are at least four service areas that frequently are overlooked in hospital laundries. These are: (1) Reclaiming of dressings, (2) cleaning and renovating of pillows and their contents, (3) cleaning and renovating of hair mattresses, and (4) processing of rubber gloves.

RECLAIMING DRESSINGS

Surgical gauze often is discarded once it has been used. This practice is wasteful and is not justified if a suitable reclamation procedure is followed. Reclamation of gauze can result in substantial reduction of surgical dressing costs. One large hospital reported a savings of $20,000 in a single year. Similar success with this procedure has been reported in veterans administration hospitals.

It has been said that lighter weight gauzes cannot be reclaimed as readily as heavier types, primarily because of shrinkage. Hospitals that have experimented with gauze reclamation, however, have found that they can reclaim gauze with 20 x 12 threads to the square inch as well as heavier gauze with a 20 x 16 thread count.

In addition to economy benefits, washed gauze has certain advantages over new gauze that make it preferable to the latter. It is softer than new gauze and has greater absorbent qualities. Many doctors believe it fits the contours of the body more readily.

Gauze that is stained with fecal matter or contaminated by spore-forming bacteria should not be sent to the laundry, but should be incinerated. It is the responsibility of the nursing department to collect the gauze that is to be returned to the laundry. It is usually collected in a container in the utility room of each nursing unit. Operating room personnel likewise collect discarded gauze sponges for return to the laundry. Once in the laundry, the gauze is kept separate from other linens.

In processing, the gauze is first given five or six separate cold water baths to rinse out blood stains. These are followed by a 10-minute hot suds bath, repeated a second time with the addition of one per cent chlorine bleach. Before draining, steam is introduced into the bleach suds and the load is boiled for 10 minutes. This is followed by three hot water rinses (180°F.) of five minutes each, and two cold water rinses, also of five minutes each. After extraction, the washing is complete.

The gauze is then stretched easily and smoothly on frames to dry. At the end of a working day, damp gauze may be placed in a dryer and left overnight. After drying, the gauze is tied into lots (usually of five pounds each) and sent to the supply room for issuance. Precautionary instructions should be given to hospital personnel that gauze is a medical and not a housecleaning fabric.

In hospitals that reclaim gauze it has been found that approximately 35 pounds can be reclaimed for every 50 pounds issued. The overall saving is estimated at 60 per cent of the price of new gauze.

HAIR MATTRESSES AND PILLOWS

Many laundry managers shy away from the processing of hair mattresses and pillows because they have heard of the difficulty in handling them. These items can be handled successfully by an alert laundry manager.

Some hospitals prefer to sterilize mattresses and pillows before washing; others reverse the pro-

Washing formula for hair mattresses and pillows

Operation	Temperature	Water level	Time
1. Suds	100°F.	5 inches	10 minutes
2. Suds	130-140	5 inches	10 minutes
3. Rinse	140	10 inches	5 minutes
4. Rinse	130	10 inches	5 minutes
5. Rinse	110	10 inches	5 minutes
6. Rinse	110	10 inches	5 minutes
7. Rinse	90-100	10 inches	5 minutes

Mr. Johnson is associated with the headquarters staff of the American Hospital Association. This article was adapted from a paper presented at the Association's Institute on Hospital Laundry Management, Chicago, May 1951.

cedure, believing that terminal sterilization has a more beneficial and revitalizing effect on the feathers. The most widely used procedure is to sterilize mattresses and pillows prior to washing. This should be done at a temperature of 240° to 250°F, and should be continued for 30 minutes in order to kill all communicable disease organisms. At the end of the sterilization period it takes about 10 minutes to discharge the steam. Mattresses and pillows should immediately be removed from the autoclave, separated and left exposed for a thorough airing. If left in the autoclave they become damp, discolored, or mildewed.

There are two methods of washing pillows: (1) With the feathers left in the ticking, or (2) with the feathers removed and washed separately in a muslin bag. The latter procedure is recommended. Little is accomplished by washing the old ticking and filling together. The ticking may be washed separately.

When washing feathers, great care must be exercised in order to avoid losing the smaller, lighter feathers and down, the best and most valuable part of the filler. A cardinal rule of the feather industry is that the lighter and plumper the pillow, the finer the grade of filling material. The trick in washing is to avoid breaking the quills. After being laundered in a washwheel, feathers (still in the muslin bag) should be dried in a tumbler. They must be completely dry before they are replaced in the covers.

A formula that may be used in washing hair mattresses and pillows is shown in the accompanying table.

When washing mattresses, no more than two suds should be used. If more than two are used the hair in the mattress may become badly matted, making it hard to repick. To prevent hair from matting, the wheel should be stopped while the load is draining. After washing, a 20 minute extraction process follows. From there the mattress goes to the tumbler for 1½ hours at 180° to 200° F. The tumbler is operated on 100 pounds steam pressure with the damper latch in the drying position.

The responsibility for washing rubber gloves is often thought to belong in the operating room or in central supply. Yet the logical place for the performance of this function is the laundry. Many hospitals have found that when carried out by the operating room department the washing of gloves is not done too well because frequently the responsibility is not assigned to one person, but is handled by whichever of the operating room personnel finds the necessary time. Centralization is indicated. After washing and drying, gloves may be returned to another department for patching and powdering. The standard laundry washing machine may be used or a home-size machine may be used.

In handling rubber gloves, as in the procedure for surgical gauze, infected ones may be separated by the nursing department before being sent to the laundry. Or, all gloves may be sent to the laundry and handled as if infected, similar to the handling of contaminated linen. This, of course, is the safest procedure to follow, since it eliminates the necessity of laundry personnel touching the gloves prior to washing. After the washing process is completed it is necessary to dry the gloves thoroughly. The use of an extractor and tumbler is not advocated since this does not get all of the water out of the fingers. A set of rollers, such as that found on a hand wringer, does a good job in removing all of the water. The upper roller should be covered with a canvas sleeve to prevent gloves from sticking together.

LAUNDRY MANAGEMENT COMMENT

Laundry controls

ANY OPERATION that involves a number of different chemicals and formulas for successful completion involves a like number of controls.

A well-put statement of the controls important to laundering appeared recently in a publication on hospital sanitation (7L-1*), issued by a prominent chemical manufacturer, and excerpted here for its potential value as a code of emphasis for the laundry manager.

"1. *Control of water supply.* Plenty of hot softened water saves on soap and detergent and makes high quality work possible.

"2. *Control of quality soap and builder,* properly balanced to get maximum detergency and whiteness retention. This prevents formation and deposition of lime soaps on work and washwheels.

"3. *Control of bleach.* Bleach is used to keep fabrics whiter, remove various stains, and to provide germicidal action. Overbleaching can cause serious deterioration of fabrics, and a definite control of its use is necessary.

"4. *Control of sour.* Sour neutralizes excess alkali left in fabrics and prevents greying and yellowing. Proper souring is important in producing beautifully finished work, but overuse of sour may cause loss of tensile strength or difficulty in finishing.

"5. *Control of rinses.* Often rinsing is hurriedly done. Insufficient rinsing may leave in the fabrics just enough of the substances used in washing, or may leave traces of unrinsed soil, to cause off-color work. Insufficient rinsing may also cause trouble in souring, bluing, or starching.

"6. *Control of blue and starch.* If the preceding controls are properly maintained and fabrics are thoroughly washed, rinsed, and properly soured, bluing and starching with quality materials will give no trouble."

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

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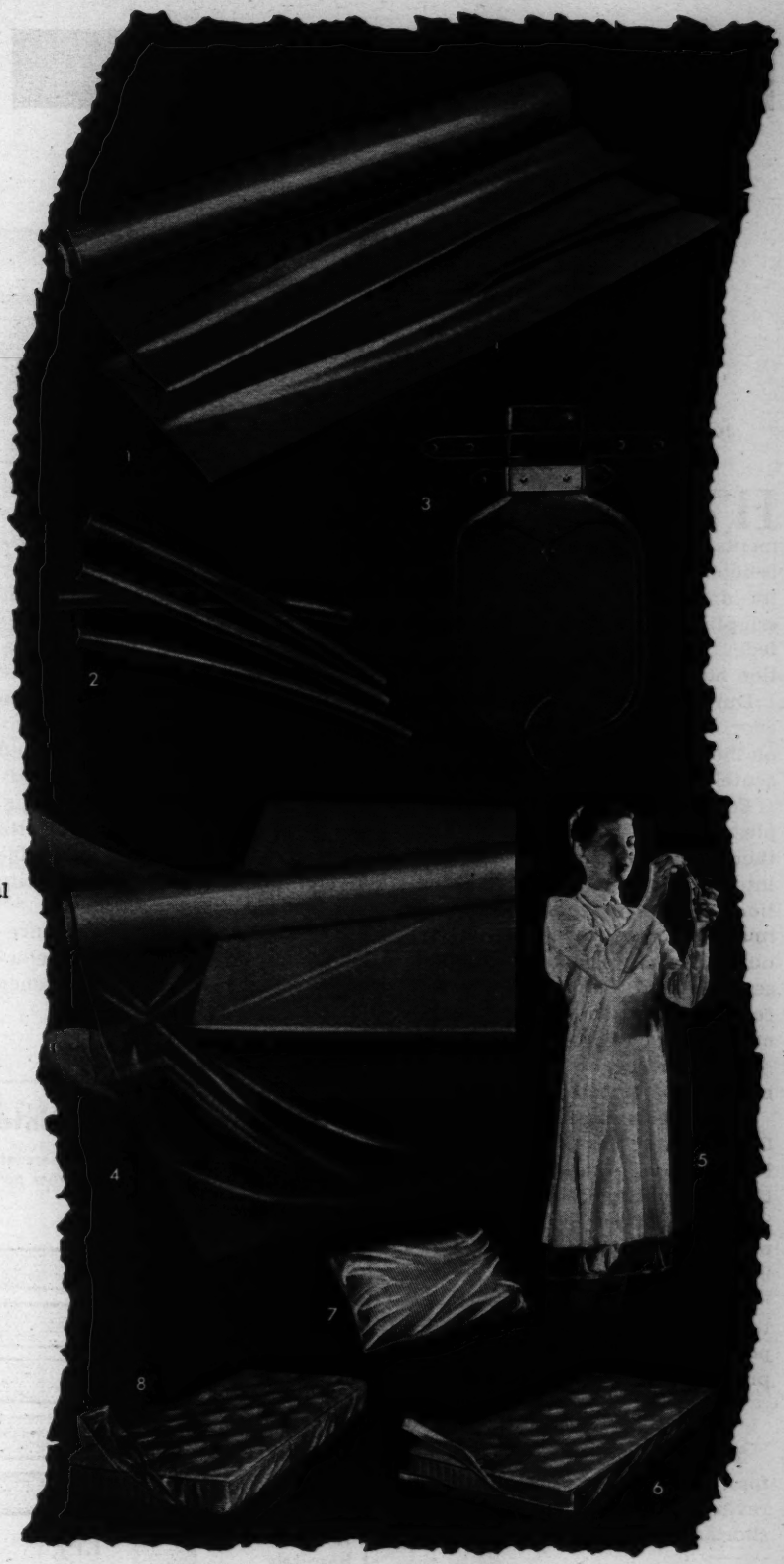

1. **AREN** hospital sheeting, a Koroseal product.
2. **AREN** brown latex drains.
3. **AREN** combination bottle.
4. **AREX** plastic film.
5. **AREX** plastic film bib apron.
6. **AREX** plastic film mattress cover.
7. **AREX** plastic film pillow cover.
8. **AREX** plastic film slip-over mattress cover.

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MEDICAL REVIEW

Health manpower and hospitals mobilize for the emergency

JOHN B. PASTORE, M.D.

HOSPITALS HAVE not yet felt the impact of military requirements for physicians. Except in isolated instances, the federal doctor draft law has not yet had a crippling effect upon either nonfederal or Veterans Administration hospitals.

During the next few years, however, hospitals will feel the needs of the armed services much more acutely.

For the coming year, for example, hospitals can expect to have their full complement of first-year interns, but there will be a reduction in first-year residents and a much sharper reduction in the number of physicians serving their second, third and fourth years of residency. The authorized strength of the military forces has increased greatly, and health manpower will be in proportionate demand.

The Health Resources Advisory Committee to the Office of Defense Mobilization, in its capacity as National Advisory Committee to the Selective Service System, has estimated a shortage of more than 22,000 physicians by 1954.

With all this, however, hospitals today still are in a much better position than they were in just prior to World War II.

A CRITICAL SHORTAGE

The supply and demand picture for our nation's health manpower reveals a most critical problem: A shortage of trained health personnel as we enter a national emergency.

On the supply side, resources are limited. Numbers of presently trained professional and nonprofessional health personnel fall short of meeting even existing demands. New recruits for training in the health and hospital field will be increasingly hard to find in a manpower market already contracted by military and industrial mobilization. Even more disturbing, many schools for training health personnel are, at present, relatively inflexible in their capacity to turn out more graduates.

On the demand side, requirements multiply daily at an accelerating rate. The national emergency has created an entirely new set of demands over and above those normally present.

THE DOCTOR DRAFT

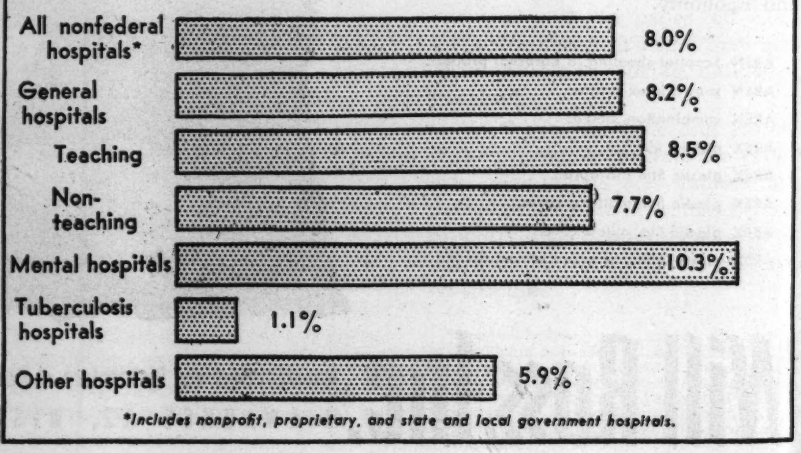
Most hospital administrators and others in the hospital field are familiar with Public Law 779 providing for the registration and draft of men in needed medical, dental and allied specialist categories who have not reached the age of 50 and are not members of a reserve component of the armed forces. Registrants are classified into one of four priority groups.

Priorities I and II include physicians and dentists with less than 21 months' active military duty since completing their medical or dental education, received in the ASTP or V-12 program or through deferment from military service in World War II. Men in Priority I, those with under 90 days active duty, and men in Priority II, those with more than 90 days but less than 21 months service after completing their training, were registered on Oct. 16, 1950.

Physicians and dentists in Priority III, with no active military service since Sept. 16, 1940, and those in Priority IV, with active duty in the armed forces but not covered by Priorities I or II, were registered on Jan. 15, 1951. Pre-

1950-51 residents and interns entering military service

The following graph shows the percentage of 1950-51 medical residents and interns entering active military service *from nonfederal hospitals*, by type of hospital, as of February 15, 1951.



*Includes nonprofit, proprietary, and state and local government hospitals.

Dr. Pastore is director of the Hospital Council of Greater New York and a member of the Health Resources Advisory Committee, Office of Defense Mobilization. This article was adapted from a paper presented at the 1951 annual meeting of the Middle Atlantic Hospital Assembly held in Atlantic City during May.

The artist has depicted a bronze XVII century Spanish mortar, ornately decorated. It has the vertical ridges and lack of handles that is typical of similar Spanish ware. The artisan who fabricated this mortar is unknown. The original rests in the Museum of the Philadelphia College of Pharmacy and Science.

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Bottles of 25 and 100, 50 mg. each capsule.
Bottles of 16 and 100, 250 mg. each capsule.
Bottles of 25, 100 mg. each capsule.

Intravenous:
Vials of 100 mg. and 500 mg.

Ointment:
Tubes of ½ ounce and 1 ounce.

Ointment (Ophthalmic):
Six tubes of ⅛ ounce each.

Ophthalmic:
Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

Otic:
Vials of 50 mg. with 10 cc. vial of diluent.

SPERSOIDS:*
Jars of 12 doses and 25 doses.

Troches:
Bottles of 25 and 250, 15 mg. each troche.

Test Tablets:
Four tubes of 25 tablets each, 0.06 mg. each tablet.

Soluble Tablets:
Tubes of 50, 50 mg. each tablet.

*REG. U.S. PAT. OFF.

liminary figures show a total of 87,856 registrants: 10,306 in Priority I; 2,550 in Priority II; 30,000 in Priority III, and 45,000, or more than one-half of all registrants, in Priority IV.

The law provides that men in Priority II will not be called until the supply of men in Priority I is exhausted, and so down the line of the four priorities. Under present arrangements with the armed forces, reserve officers are recalled in the same order. Because of this provision, the Health Resources Advisory Committee, as National Advisory Committee to the Selective Service System, feels that the establishment of a quota for each hospital would not be workable at the present time — certainly not until Priorities I and II are exhausted.

Of particular interest to those in the hospital field is the status under P.L. 779 of physicians and dentists in training at hospitals. The Health Resources Office of the National Security Resources Board, with the cooperation of nonfederal and Veterans Administration hospitals, has investigated this aspect.

Questionnaire reports covering 23,957 residents and interns at 1,200 nonfederal and Veterans Administration hospitals are the sources of the following information. No attempt has been made to project the total of 23,957 or its component parts to the actual total of approximately 25,000 physicians in the house staffs during 1950-51. All figures, therefore, represent about 96 per cent of the actual figures for the United States. The category of nonfederal hospitals includes nonprofit, proprietary, and state and local government hospitals. Since most hospitals returned the completed forms in February, the cut-off date of February 15 was arbitrarily chosen.

Interns and residents at nonfederal and Veterans Administration hospitals make up a significant proportion of all physicians registered under P.L. 779. As a group, they constitute about one-half of the registrants in Priorities I and II, 10 per cent of those in Priority III, and 20 per cent of those in Priority IV.

The 1,926 physicians on active duty as of Feb. 15, 1951, represent about 8 per cent of the total 1950-51 training year medical house staff. About 300 were men who had completed their first year internships and about 1,600 were men taking more advanced training. Almost all specialties were represented among recalled residents, and no one specialty was cut back more than 12 per cent.

Both nonfederal and Veterans Administration hospitals reported the same proportion (about 8 per cent) of house staff entering active military service. At nonfederal hospitals 1,734 of the 21,644 originally on duty were withdrawn, and at Veterans Administration hospitals 192 of their total of 2,313 had been called into the armed forces.

Fewer than one-half of the more than 800 approved *general* nonfederal hospitals had actually lost staff members to the armed forces by Feb. 15, 1951. About 18 per cent of the hospitals for mental diseases and 4 per cent of the tuberculosis hospitals reported losses.

According to these facts, P.L. 779 has not, except in isolated cases, had a crippling effect upon either nonfederal or Veterans Administration hospitals. Although the percentage may be slightly higher by this time, through Feb. 15, 1951, there had been a net loss of only 8 per cent of the physicians in training and 4 per cent of the dentists in training.

To get some idea of what effects P.L. 779 will have on hospital intern and residency programs over the next few years, it is helpful to look at the status of the present interns and residents in relation to their year of graduation, and at the composition of the present undergraduate classes in medical schools. See table on page 83.)

Most house staff members graduating before 1947 are registered in Priority IV, due primarily to service as medical officers in World War II. Later classes, those of 1947, 1948 and 1949, show the heaviest concentration of men in Priority I—ASTP and V-12 students with less than 90 days of active military service after the completion of their education. The highest proportion of men on active military duty also is found in these classes.

With the class graduating in 1950, the picture changes again. This class has its largest group in Priority IV—men who saw military service before the completion of their medical education and finished under the "G.I. Bill."

Men in Priority IV also will be the biggest group for the classes graduating in 1951 and 1952; about 70 per cent of the members of these classes are veterans of World War II. There will be few men in Priorities I and II and perhaps only 20 per cent in Priority III.

Military status: Interns and residents

Data is based on returns covering 96 per cent of residents and interns in training at approved nonfederal and Veterans Administration hospitals, as of Feb. 15, 1951.

Commissioned, priority unspecified			4,900 (20.4%)
On active duty	1,926	(8.0%)	
On inactive duty	2,883	(12.0%)	
Civilian intern and resident program	91	(0.4%)	
Registrants			15,573 (65.0%)
Priority I	3,480	(14.5%)	
Priority II	1,255	(5.3%)	
Priority III	3,053	(12.8%)	
Priority IV	7,785	(32.4%)	
Not liable under P.L. 779—female, alien, over-age			3,484 (14.6%)
Total			23,957 (100.0%)

FUTURE PROSPECTS

For next year, then, hospitals can expect to have their full complement of first-year interns; some reduction, possibly 15 per cent, in the complement of first-year residents; and a much sharper reduction, probably one-third or more depending on the military needs, in the potential supply of second-year, third-year and fourth-year residents, those drawn from the graduating classes of 1947, 1948 and 1949.

Possible offsets to these losses are (1) retaining a larger-than-usual number of the classes of 1946 and earlier, and (2) retaining a larger number of women and aliens. It seems certain, however, that the greatest shortage in the 1951-52 training year will be in senior residents, since these men are now primarily registered in Priority I.

As soon as the first two priorities are exhausted and the concentration of draft pressure reaches Priority III (men with no military service since September 1940) the picture will be somewhat different. Withdrawals from this group would put a more uniform pressure and a smaller total pressure on the classes as far back as 1948.

Next year undoubtedly will see further reductions in the size of resident staffs. The present military picture, however, coupled with the more economical utilization of its medical officers by the armed forces, does not indicate anything approaching the cuts necessary during World War II. After another year it may be possible to stablilize the recruiting of medical personnel at a level that will just provide replacements for those officers whose tours of duty have been completed.

This fact, together with the legal requirement that Priorities I and II must be exhausted, in that order, before Priority III can be drawn upon, has brought about an entirely different situation from that faced by the Procurement and Assignment Service of World War II. The quota system used during the last war would be very cumbersome, if not impossible, to operate within the present system of priorities, determined not by relative needs among the states but by the military background of each individual.

BETTER THAN 1940

Even after losing the services of the physicians who had already entered active military service by Feb. 15, 1951, hospitals today are in a much better position than they were prior to World War II. Since 1940, medical house staffs have increased by 77 per cent, from 14,100 in 1940-41 to roughly 25,000 in 1950-51. Patient loads have shown smaller increases: 69 per cent in admissions and 21 per cent in daily census.

The outlook for the future is quite different. Between 1950 and 1951 the authorized strength of the military forces increased by two-and-one-half times; it now stands at 3.5 million men. Accordingly, health manpower will be in greater demand.

For every 1,000 men inducted, the armed forces require four physicians, but only one physician on the average normally serves this many individuals in civilian life. If these standards are maintained, the increase in needs for the country as a whole is three physicians for every 1,000 inductees. With the added military demands and with the present rapid expansion in our total population, the ratio of physicians available to the civilian population will necessarily decline as the military mobilization gains momentum.

It is most important, however, that we maintain rather than lower the 1949 ratio of physicians to civilian population. This ratio is the same as it was in 1940; the expanded wartime output of physicians was offset by a population increase of some 20 million during the decade.

Looking ahead, the Health Resources Advisory Committee has estimated a shortage of 22,200 physicians, 9,200 dentists, and 49,200 nurses by 1954. This estimate is based on the current level of graduates and assumes: (1) We should maintain our 1949 civilian population ratio and service; (2) we should meet the additional requirements of civil defense, industry and public health services, and of staffing health schools, and (3) we must meet the needs of the armed forces, which we estimated at a strength of 5,000,000.

RECOMMENDATIONS

To overcome these shortages, the committee has recommended that the number of enrollments and graduates be increased. To date the Health Resources Advisory Committee has made estimates of future requirements for only physicians, dentists and nurses. The committee, however, has pointed out to Selective Service and the local state committees the critical shortages existing among other types of hospital personnel.

We can profit by our experience in World War II, especially if we realize that it was limited in many respects. We escaped epidemics, including influenza, the number one killer of World War I. In addition, this country was never subjected to air raid attack. We must be prepared to meet both epidemics and air raid attacks, as well as biological warfare and atomic bomb attacks.

Our goals are clearly defined. We must do all in our power to keep both the civilian and military populations in a state of peak fighting efficiency at all times. In the immediate future we must concentrate on doing this within our limited supply of health manpower. In the years ahead we must increase our health manpower to meet the demands already upon us.

Military status by year of graduation

The following table shows the military status, by year of graduation, of medical interns and residents.

Year of graduation	Number	Percentage Distribution							
		Total	Priority group I	II	III	IV	Prior reserve commission	On active duty	Females, aliens and over-age
1944 and prior	5,500	100	2	6	12	47	12	2	19
1945	2,400	100	4	9	4	57	17	2	7
1946	3,100	100	10	2	5	58	14	5	6
1947	2,600	100	41	5	11	6	9	17	11
1948	3,000	100	30	8	16	9	10	12	15
1949	3,100	100	23	6	19	11	9	11	21
1950	5,300	100	9	3	18	36	14	6	14

Modern Xavier Hospital relies on Modern GAS Cooking

THE HOSPITAL: Xavier Hospital in Dubuque, Iowa, is a modern 100-bed establishment under the direction of Sister Mary Marcellus, O.S.F., Superior and Superintendent.

THE COOKING TASK: 500 meals a day must be prepared for patients and members of the hospital staff. Not only must regular meals be cooked quickly and appetizingly, but special diets must be catered to at the same time. All pies, cakes, bread and pastries are baked at the hospital too.

THE COOKING EQUIPMENT: To prepare 500 meals a day, the hospital uses the following Modern Gas Equipment in its compact, efficient Gas kitchen: **Blodgett Gas Oven; Vulcan Gas Range unit composed of 2 hot tops; French Fryer; Broiler.**

THE GAS COOKING FACTS: Cooking with Blue Flame GAS saves work. Automatic GAS Temperature Controls save time, effort and work for the Xavier Hospital kitchen employees. Gas gives the cooking and baking temperatures they want when they need them . . . fast.

HOW GAS COOKING CAN SERVE YOU: Blue Flame Gas cooking is clean. Gas is dependable, efficient, and economical. Modern Gas Equipment is the answer to modern cooking problems. Call your Gas Company Representative today. He will show you the values of using Modern Gas Equipment in your kitchen.

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In the June issue of HOSPITALS, Mr. May discussed the initial planning of a new dietary unit at his hospital. The accompanying article describes the department's physical layout.

Remodeling an outdated dietary unit into a modern department

ERNEST N. MAY

In changing from an old dietary department to a new, our 180-bed general hospital discovered many obstacles to overcome. Buying new equipment, renovating old equipment, types of equipment — all these factors entered into the changeover. The first step, however, was to decide upon proper areas and relative location for the 17 categories comprising the department.

These included everything from a receiving dock through dry stores; refrigeration, preparation and cooking to tray assembly; and cafeteria dining room to dishwashing. They excluded garbage and refuse storage, two important functions provided for in a separate building. The size of the department was predicated on a possible 25 per cent expansion in both patients and personnel.

Eventually the entire area totalled 8,400 square feet. The final layout and space allotment to various units is indicated in the accompanying floor plan. Incidentally, all entrances to the dietary department have solid doors equipped with good locks. This was done to eliminate unauthorized access to food supplies.

The importance of saving time to save heat was discussed in last month's article. It is less important, but very desirable, to save time to save both taste and appearance (salads, for instance). Under these double spurs to reduce total elapsed time to the minimum, the first attack was on the tray assembly procedure. A manually operated assembly line was designed so that the entire operation from bare tray to dispatched tray progressed in a continuous, rapid sequence.

This assembly method is probably the only novel procedure in the new department and is the crux of the entire system. At the beginning of the line is the first station, where one operator, standing at a specially designed cabinet, takes items such as the tray and the paper mat from their respective "pigeon holes." Then basic room temperature items, such as paper napkins, silverware, glassware, saucers, salt, pepper and sugar, are placed on the tray.

The operator then places these partially assembled trays on the tray slide and pushes it along to the next station. As the tray moves down the slide, it is served according to the menu marked on the tray card for each individual patient. Cold foods such as butter, milk and salads are put on first; then the steam table items are added, and, finally, the hot beverage. Last of all, the exact contents and appearance of each tray are separately checked by the supervising dietitian.

The assembled checked trays are then placed in unheated, closed food trucks for the quickest possible delivery to the floors. The trucks are unheated so that the complete assembly, including chilled foods, may be handled at one time and at one place under the absolute control of the dietary department. Otherwise hot and chilled foods would have to be sent separately to the floors to be placed on the trays by either additional dietitians or by certainly disinterested and relatively untrained floor workers, with consequent risk of error with all its unhappy results.

Ten or 12 food trucks can create their own parking problem. In this case, the layout is such that the trucks can be parked right inside the door leading to the patients' floors and adjacent to both tray loading at the tray assembly line and to tray unloading in the dishwashing section. This gives the trucks the minimum delivery distance, keeps them out of the kitchen, and (when parked or being cleaned) out of everybody's way. An area of 500 square feet of floor space was required to accomplish these objectives.

Despite good cooperation in this matter by the nursing department, it was planned to assign the responsibility for tray delivery to the dietary department on the principle that authority must extend as far as responsibility. There would also be fewer chances of alibis or errors with one line of authority extending directly to the bedside, and this would be the surest way to maintain speed in serving.

In considering the allocation of dining room area space, there arose a positive need for estimating as accurately as possible the number of persons the dietary department would be serving 20 years hence.

This was doubly important because the area involved was by far the greatest single space, about 20 per cent of the total. Ten per cent of dining room space saved was equivalent to either one of the

Mr. May is a hospital trustee and a member of the building committee that planned a new dietary department for his hospital.

The Dietetics Administration department is edited by Margaret Gillam, dietetics specialist.

smaller but very desirable categories, or to $7,000.

It was decided to allow for a future 25 per cent increase over the present staff. This set the total population figure.

The dining area, of course, is dependent upon the number of persons eating at a given instant. Evenly "staggering" the noonday peak is the dream of every food purveyor, but it is seldom successful very long. It was concluded that 60 per cent of the total load would be the peak that must be accommodated at once, in the first and heaviest of essentially two periods. As a recourse there is always the possibility of further "staggering" into three periods.

There arose another key question. How many square feet per seated person? Expert opinions varied all the way from 12 to 20 square feet. These areas are exclusive of counter space.

The former dining room seated 57 persons in 585 square feet or about 10 square feet per person and it was too crowded. A neighboring hospital allowed 20 square feet per person and the dining room looked deserted most of the time.

On the premise that a dining room is an investment in personnel relations, the committee settled for 15 square feet per person. This required 1,830 square feet to meet the planned 25 per cent expansion.

It was unhesitatingly decided to concentrate all dining facilities in one room, including those for residents, interns, and permanent staff, as well as for visiting physicians Also included are laundry, housekeeping, maintenance and dietary employees. The use of all table linen was abandoned as wanton waste for an institution continually appealing for charitable funds. Paper napkins were adopted.

The dining area can be entered only through one special corridor that connects with the main building. This corridor is six feet wide to allow for the passage of incoming and outgoing traffic without conflict. In addition, there is a fire exit. A traffic rail enforces one-way traffic during meal hours.

After eating, each individual removes his soiled dishes, placing his tray in a pass-window in an extension of the corridor leading to the cafeteria. The disposal window is not readily visible to those coming in to their meals.

Refrigeration was a particularly knotty, controversial problem. Somebody had to decide upon "x cubic feet of deep freeze." The determination of "x" became involved in the comparison of quality of the finished product with the true cost of production and of fresh versus canned versus quick-frozen foods. There were the further variables of "what foods and for what seasons?" All the published material available to the committee was either so carefully hedged or so obviously biased that it was worthless.

Finally the committee turned to and analyzed its own hospital's food purchasing records habits and apparent preferences over a 12-month period. Out of it evolved the too-easy conclusion that the real decision was more financial than dietary and accordingly was a question for the board.

In the end it was decided to install 100 square feet (750 cubic feet) as a permanent deep-freeze box at −10°F. Adjacent to this, another walk-in box was insulated and fitted to run at either −10°F. or higher, as desired. This dual purpose box added 60 square feet (450 cubic feet) as auxiliary deep-freeze capacity. Thus the maximum installed deep-freeze capacity was 1,200 cubic feet, which included aisle space. Actually, it was not 100 per cent storage. This was a compromise between what seemed amply reasonable and economical at the time and made provision for the future.

The following capacities were decided upon in the more familiar types of refrigerators: (1) For dairy products, 60 square feet (450 cubic feet) at +40°F.; (2) for vegetables, 100 square feet (750 cubic feet) at +40°F.; (3) for meats, 120 square feet (810 cubic feet) at +36°F., and (4) as an extra—the aforementioned dual purpose box of 450 cubic feet.

For greater control over the amount of food and for convenience, "reach-in" refrigerators were provided in four areas to supplement the "walk-in" boxes. With the "reach-ins" close at hand, it became unnecessary for an employee who needs only a small amount of an item to go to the "walk-in" boxes, which are intended mainly for storage of items included in an entire day's menu. Not only the chef but also the bakery and salad units have individual "reach-in" boxes equipped to handle made-up items. The box originally ordered for the diet kitchen was diverted to nourishments.

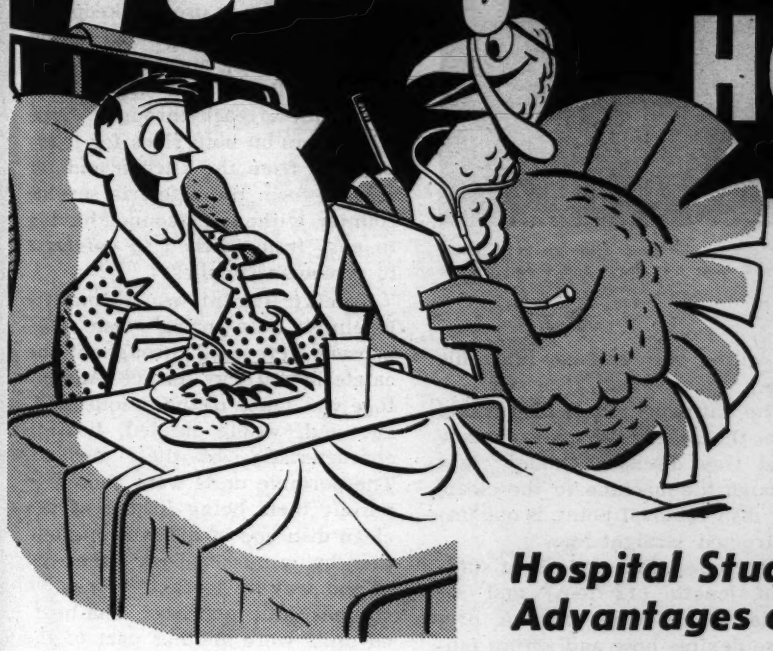
A "reach-through" refrigerator was built into the wall between the salad preparation section and the cafeteria service aisle to insure thorough chilling of prepared salads and desserts. These are placed in the refrigerator from the kitchen side and are withdrawn as needed through separate doors on the cafeteria side. Congestion is thus avoided.

The accompanying floor plan should be carefully studied to appreciate the almost straight line flow of materials achieved by the layout. Spaces for these various functions were separated from each other by arranging their respective equipment so that the equipment itself formed limiting barriers. Thus each preparation unit not only had its own separate facilities, but it had them without partitions. Wherever possible, partitions were avoided in order to: (1) Save their cost of installation, their cost of maintenance, and the daily steps taken to walk around them; (2) improve ventilation and supervision.

Particular emphasis was given to salad preparation by providing, first, the separate "reach-in" refrigerator in the unit itself for keeping the already prepared salads on trays; second, the "reach-through" refrigerator supplying the cafeteria; third, the refrigerated plate at the cold end of the tray assembly, and, fourth, the flaked ice pan in the cafeteria counter.

The cook's unit was deliberately placed right in the center of the kitchen area. It was oriented so that its raw materials would flow in from their respective preparation areas. Then the cooked foods would proceed in the same general direction either to tray service steam tables or to the cafeteria

Turkey's in the HOSPITAL



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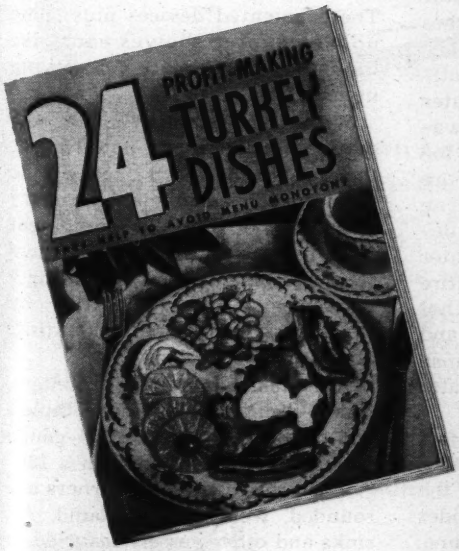
- **Portionwise, turkey is most economical to serve.**
- **It may be cooked like other meats . . . roast, braise, broil, or fry it.**
- **It is popular with patients every day of the year.**
- **It's a real time saver . . . may be prepared in slack hours — reheated before serving with virtually no loss.**



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By.....

DINING AREA was planned to allow 15 square feet per person even after an anticipated 25 per cent future increase in personnel. Diners remove their own trays and soiled dishes.

food warmer. As mentioned earlier, a separate "reach-in" refrigerator was also furnished the chef.

One of the additions to the new department was a bakery. Under the former system all baked goods were purchased from outside sources, with the result that desserts were neither particularly varied nor appetizing. Bread will continue to be purchased, but it was felt that the bakery investment was justified by the addition to the menu of hot rolls, homemade pies, cakes, and puddings. One of the considerations in the deep-freeze problem was the ability to bake many items at convenient times and store them in the deep-freeze for later use or for special occasions.

Space was provided for an ice cream unit and water and steam connections were put in, but no equipment was purchased. It was deemed wise to get into ice cream making only after more important things had been successfully accomplished.

Care was taken to establish the vital dishwashing function on an equal basis with the others, *i. e.*, in equipment, in operating efficiency, in appearance, and in working conditions. It was determined that this was to be one adequately designed and decently located dishwashing unit if there never were another. Ventilation was given special consideration and the acoustic ceiling was carried into this area.

The entire length of dish travel from the soiled dish pass-window (and tray discharge table) right through the machine to the clean, dry dish removal point, is one unobstructed straight line.

The soiled dish table is of sufficient length (12 feet) and includes a pre-rinse sink. A pre-rinse flexible hose and spring faucet extend far enough (18 inches) across the table so the operator can successfully spray the dishes rather than himself.

The dish machine is automatically timed in cycle and water temperatures. The customary water temperature dials in three locations are easy to read, but more important is the installation of an entirely separate, specially designed and equipped hot water generating system for the entire dietary department. Adequate hot water generator, storage tank and booster were provided to furnish all the 140°F. and 180°F. water needed.

The clean-dish run off is 15 feet long to permit the dishes to dry thoroughly before reaching the end. The extra length provides flexibility in the operator's time. The dish rack return is a roller-bearing track straight along the back wall.

There is, in addition, a 12 foot tray discharge table, a separate soiled dish soak sink, a separate silverware soak sink, a two-spindle glass washer with appropriate table area, a silver burnisher and stainless steel wire dish racks.

The 12 foot pot sink consists of one single compartment sink, one swill sink and one double compartment sink with a drainboard on each end of the assembly.

A six-cabinet unit in the cafeteria back bar is used to keep hot food hot during the critical period between cooking and serving, thus retaining flavor and appearance. It is the "reach-through" type with doors on both sides for loading food from the kitchen and for serving from the cafeteria service counter without personnel having to pass from kitchen to cafeteria to replenish supplies.

Twelve ingenious, automatic leveling, base-spring dish dispensers were used throughout the cafeteria and tray service. Advantage was taken of the unique storage and, where needed, heating characteristics of these devices. The portable units were chosen to permit their being loaded at the clean dish end of dishwashing and then being pushed back either out of the way or to their respective stations until next used. The heated units were another part of the attempt to start the food out hot and to keep it hot until served. These patented devices plus some under-counter shelves comprise the only storage place for serving utensils.

With the exception of a few pieces (the relatively new ranges, the usable 60-quart kettle, the potato peeler and the old steamer) every bit of the old equipment was replaced by new stainless steel equipment, used unstintingly wherever so indicated either by cleanliness, exposure to cutting, abrasion or corrosion.

All kitchen table tops, counters, sinks, drainboards, steam tables, and double boilers are of 14-gauge stainless steel finished with a 180° ⅜-inch raised roll. All corners are rounded, welded and ground. All sinks and other vessels designed to hold water have all vertical and horizontal interior angles rounded to a ¾-inch radius. Wherever they are placed against walls, all the foregoing equipment is carried up

Clock tower of magnificent Reading Hospital, Reading, Pa. Exacting standards of service are maintained throughout every department.

THE READING HOSPITAL

Reading, Pennsylvania

E. ATWOOD JACOBS, ADMINISTRATOR

Dear Sir:

Responding to your inquiry about Mealpack, a pilot installation was installed and thirty private obstetrical patients were served for a period of five weeks.

The reaction of patients, physicians, nurses and dietary staff was wholly satisfactory and the results of this trial run convinced us that Mealpack is the only satisfactory method of inaugurating central tray service. Previous experience with both decentralized and centralized food service revealed that neither system met the needs of patients. With the decentralized system and its dual handling the food lost its palatability. Delays in serving in a central system resulted in patients receiving cold food. All of our experiments and investigation in the field convinced us that Mealpack permits the serving of hot, palatable food to patients with greater efficiency than any food service system that has come to our attention. Furthermore, it offers economies that are otherwise unattainable.

Plans are now being consummated to install Mealpack in the entire hospital and we will ultimately serve 450 patients.

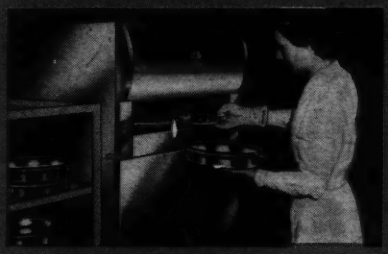
I regret that time does not permit me to discuss all of the advantages of Mealpack, but if you should be in this vicinity do not hesitate to visit us and we will show you Mealpack in operation.

Sincerely yours,

E. Atwood Jacobs
Administrator

EAJ:mm

MEMBER OF COMMUNITY CHEST



Dietitian Jeanne Veltz *pre-heats Mealpack Containers' inner Pyrex dishes in Mealpack Dish Heater. After this simple routine, hot meats, vegetables, rolls, etc., are vacuum-sealed in insulated Mealpack Containers, ready for tray set-up at main kitchen and for flexible distribution via Mealpack Tray Carts.*

Student nurse Shirley Westman *adds soup, hot beverage and ice cream to one of the 20 trays carried on each trip of Mealpack's Tray Cart. Each Cart rolls from main kitchen direct to floor serving areas. Literally a "portable floor pantry." Delayed trays may be served up to 2 hours after provisioning!*

EVERY HOSPITAL WITH A FOOD SERVICE PROBLEM will find real food for thought in the above letter. Written by an outstanding Administrator, it answers many hospitals interested in Reading Hospital's reasons for converting its buildings (450 beds) to MEALPACK service for all patients.

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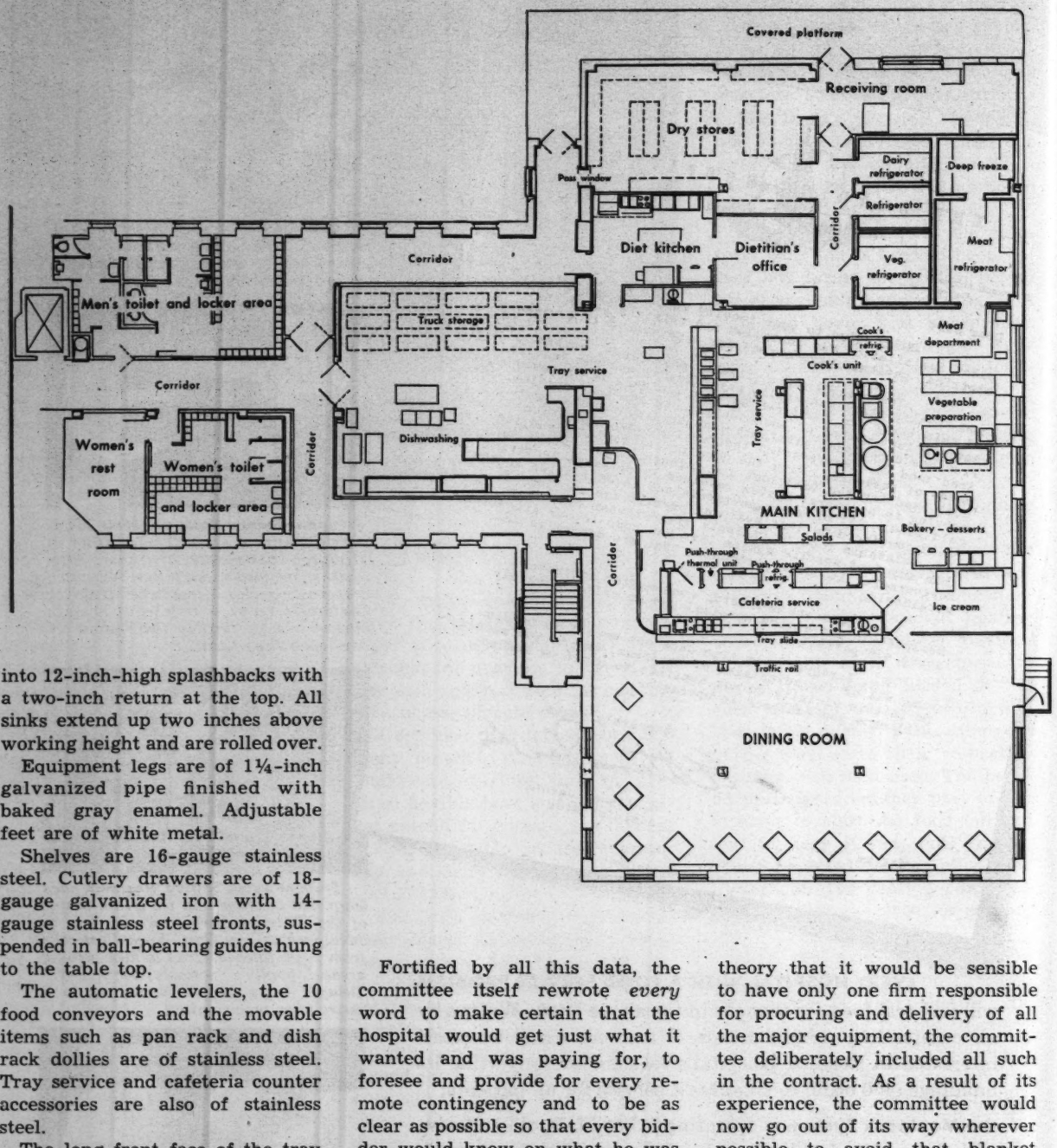


into 12-inch-high splashbacks with a two-inch return at the top. All sinks extend up two inches above working height and are rolled over.

Equipment legs are of 1¼-inch galvanized pipe finished with baked gray enamel. Adjustable feet are of white metal.

Shelves are 16-gauge stainless steel. Cutlery drawers are of 18-gauge galvanized iron with 14-gauge stainless steel fronts, suspended in ball-bearing guides hung to the table top.

The automatic levelers, the 10 food conveyors and the movable items such as pan rack and dish rack dollies are of stainless steel. Tray service and cafeteria counter accessories are also of stainless steel.

The long front face of the tray service counter is galvanized iron finished with baked gray enamel.

All of the equipment embodied in the so-called "kitchen equipment" contract was very carefully specified. The specifications themselves were prepared first by a prospective contractor, then checked and revised by the architect. This second draft was submitted to the committee, which had also two other sets of meticulously prepared "specs."

Fortified by all this data, the committee itself rewrote *every* word to make certain that the hospital would get just what it wanted and was paying for, to foresee and provide for every remote contingency and to be as clear as possible so that every bidder would know on what he was bidding. In this way, all bids would be truly, fairly comparable. As finally completed, the specifications covered 18 single spaced pages for the general conditions, and 15 pages for the further detail of the 60-odd individual items. This extreme care was later justified. The only minor question on contractual interpretation was whether a steam table is or is not a double boiler.

On the slightly more expensive theory that it would be sensible to have only one firm responsible for procuring and delivery of all the major equipment, the committee deliberately included all such in the contract. As a result of its experience, the committee would now go out of its way wherever possible to avoid that blanket method.

A diet kitchen was built solely to satisfy the administrator and the chief dietitian, although overwhelming evidence in the committee's hands indicated that the idea of a diet kitchen had been outmoded 20 years ago. The space was converted to better purposes when both adherents left the organization before the diet kitchen was completed.

The dietitian's office was cen-

trally located, with windows across one entire side to give her a full supervisory view of the kitchen. Another window faces three of the "walk-in" boxes. One door of the office permits salesmen to call without having to go through any part of the department.

The 180 square feet allocated to this office proved (even before completion) to be only half as large as was needed, but, fortunately, the adjoining diet kitchen, as explained earlier, could now be taken for clerical and office space.

The walls are of buff-colored non-glaze tile extending from the floor to the ceiling in the food preparation and cooking areas, the dishwashing unit, offices and "walk-in" boxes. In the dining room the same tile walls go up only five feet from the floor and the rest of the wall from that point to the ceiling is pale green plaster.

It was originally intended to leave about three inches between all equipment and the walls for ease of cleaning and maintenance. Then, in a moment of economy and to save only about $1,000, this fine idea was abandoned.

Floors throughout are of sand-colored four-inch quarry tile wit the exception of the dry stores and receiving areas, where the floors are of painted concrete. In spite of a strong desire to have numerous floor drains in both cafeteria and kitchen floors so that the entire area could be washed down, building code difficulties were encountered because of fear of back-flow, so the drain idea was reluctantly discarded. This meant that portable mop buckets had to be used entirely.

Because of unavoidable noise from hard surfaced walls, floors, equipment and utensils, the ceilings throughout were acoustically treated. The type selected consisted of perforated aluminum pans backed up by rock wool pads. Metal pans were chosen to facilitate frequent cleanings and aluminum to avoid inevitable rusting from any abraded finished surface.

Forced circulation of air rather than air-conditioning was adopted because it offered the advantages of (1) being much less expensive to install and operate and (2) continually bringing in fresh air from the outside. The exhaust hoods overhanging the ranges and kettles extend approximately three feet beyond to carry off fumes from those operations. In addition there is a complete over-all air change throughout the processing areas every three minutes.

Recessed prismatic glass lens units control the lighting system and provide high-quality diffused light from 40-watt fluorescent lamps operated at a color temperature of 4,500 degrees white. This type of lighting provides daylight vision and precludes distortion of the color of foods.

Glass brick windows were installed in the kitchen. This style should result in a cleaner department by avoiding open windows, dirty window ledges and window panes, dirty screens and dirty venetian blinds. Conventional windows were used in the dining room.

Nylon press cloth draperies, which could be easily washed in the hospital laundry, were chosen in preference to venetian blinds because of ease of maintenance and cleaning. The draperies are a print in yellow and green pastel tones.

A special hand-wash sink and a drinking fountain were put near the employee's entrance to the kitchen proper. Half of the former dietary department area not occupied by the new dishwashing unit and truck parking space was converted to two badly needed locker rooms (with showers) for both men and women.

Invitations to bid were sent only to those contractors whose bids, if lowest, would be acceptable. When the bids were opened, the total minimum cost of the undertaking began to look about as follows:

Rearranging roads, sidewalks; adding new ones	$ 5,000
Building construction	200,000
Equipment	40,000
Fees—architects and engineers	17,000
Miscellaneous (bond, insurance)	3,000
	$265,000

Although this was the sharpest possible figuring, leaving nothing for contingencies, the bids were accepted and ground was broken in mid-September 1949.

DIETETICS ADMINISTRATION COMMENT

Two valuable books

TWO RECENTLY published books will be of interest to dietitians and institution food service managers. Producing good food through the use of the standardized large quantity recipes in "Large Quantity Recipes," by Margaret E. Terrell, and modernizing the special diet service through emphasis on an adequate diet for all special diets as recommended in "Modern Dietetics," by Doris Johnson, should effect a higher quality of food service in most hospitals and institutions.

Large Quantity Recipes[1]: This is a completely remodeled volume of "Quantity Food Service Recipes" prepared by the American Dietetic Association about 11 years ago. In the new edition, the contents are organized according to menu courses. The 400 recipes now included were tested by experts in the field and approved by a panel of judges. Recipes are provided for each course in the meal, which is an aid in making available a variety and a very complete service of recipes needed for hospitals and other institutions.

The recipes are easily adaptable for hospital use, as each is standardized in quantities of 50 servings with the ingredients given in weight and volume. This book is recommended to every hospital preparing food for 50 or more persons and to all hospitals for its suggestions for adding zest and variety to meals.

Modern Dietetics[2]: Of special interest to hospitals will be this completely new work designed to meet the requirements of present day thought and practice in die-

tetics. The book has been developed about the central theme of the normal diet. A "basic daily dietary pattern" is designed to supply amounts of nutrients in accordance with the "recommended daily dietary allowances" promulgated by the Food and Nutrition Board, National Research Council. This basic pattern forms the suggested dietary plan for the normal or regular hospital diet and its modification in one or more constituents required in treatment of diseases. The manner of presentation is according to the present trend toward a small number of basic diets for the treatment of diseases rather than a special diet planned for each disease.

The book was prepared, according to the author, to serve as a text for the student who is planning for a career in some area of the modern health program and particularly as a text for the student of nursing.

Part I deals with normal nutrition and its relation to the individual's well being. Emphasis is placed on individual nutrients necessary for normal nutrition, their functions in the body and the kinds and amounts of foods required daily to supply the recommended allowance. The author discusses the part of each of these essential nutrients in the "basic daily dietary pattern." Infant feeding and nutrition requirements through the period of growth, as well as for the aged, are included.

Part II covers the modern treatment of disease by diet. Each diet is planned according to the "basic daily dietary pattern" to assure that the normal or regular hospital diet and therapeutic diets which are planned as modifications of the normal diet meet the nutritional requirements for adequacy. For each diet a suggested dietary plan is given, and parallel with this is the menu adaptation for the three meals. When quantity of food is important, as in the high caloric or low caloric diet, the size of the serving is listed for each food.

Few if any books or manuals on dietetics have presented diet therapy in such concise, direct and understandable form. This consistent form is followed in discussing each diet: The principle of modification of the normal diet for the therapy of each disease; the condition or impairment of body function that requires a modification in the selection of foods, consistency, protein, fat, carbohydrate, energy value or minerals; planning the diet; adequacy of the diet; suggested dietary plan and menu adaptation; foods allowed and foods to avoid.

Part III is a discussion of the selection, care, preparation and cookery of foods. The author states that this is written to correlate with her previously published "Laboratory Manual for Cookery" based on the meal-plan system.

The charts, tables and information in Part IV are valuable aids. The "food composition table for short method of dietary analysis" and the "food composition table" are necessary references for the practice of dietetics.

This book is recommended to dietitians and other persons responsible for food service in institutions. Hospitals that adopt the diet therapy plan suggested by Miss Johnson will find it easy to follow. This method will bring about simplified special diet planning and improve food standards.

1. LARGE QUANTITY RECIPES. Margaret E. Terrell, M.A., professor of home economics and director of University Dining Halls, University of Washington, Seattle. Second Ed. Philadelphia, J. B. Lippincott Co. 1951. 414 p. $7.

2. MODERN DIETETICS. Doris Johnson, B.S., M.S. Edited by Hazel E. Munsell, Ph.D. New York: G. P. Putnam's Sons. 1951. 529 p. $4.95.

Master Menus for August

The August series of the American Hospital Association's Master Menu is printed on this page and the following pages.

The meals for August are part of a new and revised Master Menu service. Full details of the new Master Menu will be published in HOSPITALS for August. Special mail announcements and literature will be mailed to hospitals before that date.

The Master Menu reduces to a minimum the number of diets, simplifies planning, cuts costs and conserves food preparation time. The normal diet forms the basis of the seven most commonly used special hospital diets. The menus are adaptable for selective service by greater variety in the choice of the dinner and supper meats.

Besides considering food essentials and servings required for nutritional adequacy, the Master Menu also takes into account such factors as flavor, variety, attractiveness and general acceptance by patients. Color combinations are planned to harmonize. Foods in each meal are planned in a variety of forms, so that each tray is pleasing to the eye. Consistency, too, is important, and here the accent is on variety also. If some foods are served in a soft form, a crisp food is included in the meal. Flavor gives zest to a meal, and this aspect receives consideration in the planning.

To use these menus, (1) read the selections for the normal **(bold-face type)** and seven special diets, (2) type the day-by-day menu suggestions on transfer slips, spaced and numbered to correspond with the Master Menu wall charts, and (3) attach the completed slips on the spaces and corresponding numbers on the breakfast, luncheon or supper, and dinner wall charts.

August 1

1. **Sliced Orange**
2. Orange Juice
3. **Rolled Wheat or Corn Flakes**
4. **Poached Egg**
5. Grilled Ham
6. **Whole Wheat Toast**

7. ***Beef Bouillon**
8. **Crisp Crackers**
9. ***Veal Birds with Savory Stuffing**
10. Plain Baked Veal Pattie
11. **Whipped Potatoes**
12. Steamed Potatoes
13. ***Baked Eggplant or Spinach, Lemon Wedge**
14. Fresh Spinach, Lemon Wedge
15. **Cabbage and Raisin Salad**
16. **Cream-Vinegar Dressing**
17. **Vanilla Ice Cream, Strawberry Sauce**
18. Vanilla Blanc Mange, Cherry Juice Sauce
19. Raspberry Gelatin
20. Bing Cherries
21. Grapefruit Juice

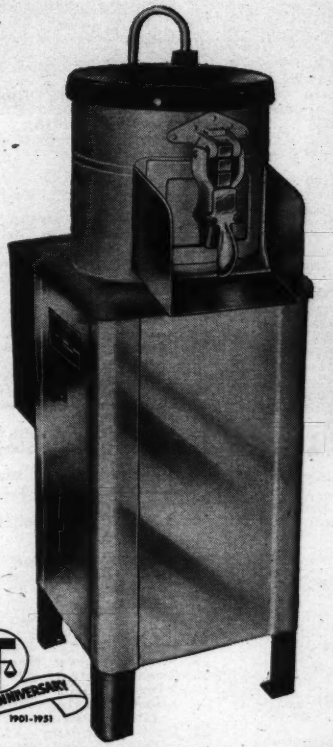
22. ***Cream of Asparagus Soup**
23. **Croutons**
24. **Lamb Souffle, Parsley Cream Sauce-Currant Jelly**
25. Plain Lamb Souffle-Currant Jelly
26. Cold Roast Lamb
27. Baked Potatoes
28. **Sliced Carrots**
29. **Escarole, Chicory and Romaine Salad**
30. **Clear French Dressing**
31. **Fresh Pear**
32. Canned Pears
33. *Vanilla Blanc Mange
34. Fresh Pear
35. Blended Citrus Juice
36. **Whole Wheat Bread**

August 2

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Puffed Rice or Granular Wheat Cereal**
4. **Scrambled Egg** (Omit on Low Fat Diet)
5. Link Sausage
6. ***Pecan Rolls**

7. **Mushroom Bouillon**
8. **Saltines**
9. **Cubed Steak**
10. Broiled Cubed Steak

*Asterisks throughout these menus refer to recipes in "Large Quantity Recipes." See Dietetics Administration Comment on page 91.



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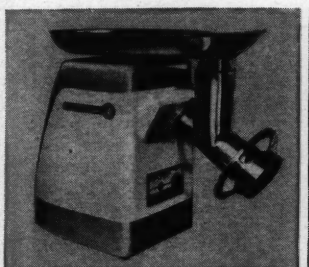

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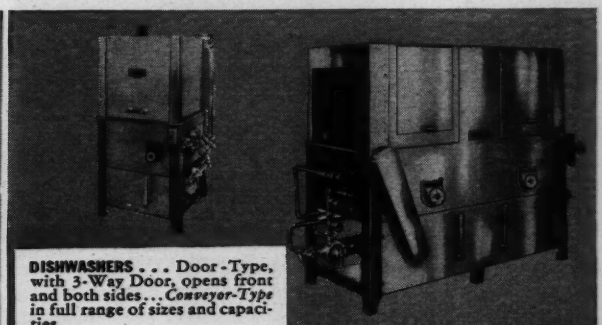

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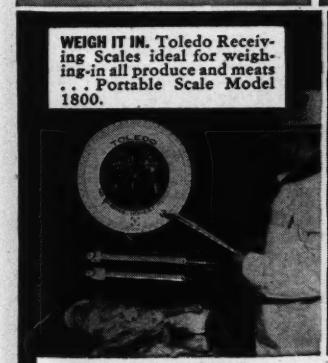

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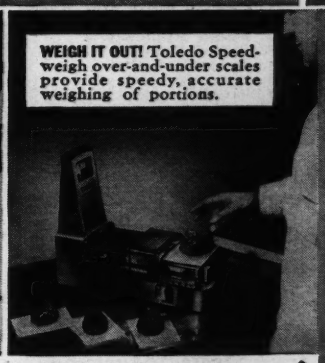

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11. **Browned Potato Balls**
12. Potato Balls
13. **Cauliflower with Cheese Sauce**
14. Sliced Beets
15. **Escarole with Julienne Beet Garnish Salad**
16. **Clear French Dressing**
17. **Coffee Ice Cream**
18. Coffee Ice Cream
19. Orange Ice
20. Honeydew Melon
21. Limeade

22. ***Cream of Spinach Soup**
23. **Crisp Crackers**
24. **Mixed Grill—Chicken Livers, Bacon, *Grilled Tomatoes**
25. Broiled Chicken Livers—Crisp Bacon—Asparagus
26. Chicken Livers—Plain Grilled Tomatoes
27. Steamed Rice
28. ———
29. **Vegetable Salad Relish**
30. **Celery Seed Dressing**
31. **Sliced Fresh Peaches**
32. Canned Peaches
33. Baked Custard
34. Sliced Fresh Peaches
35. Pineapple Juice
36. ***Cornbread**

August 3

1. **Banana**
2. Blended Citrus Juice
3. **Hominy or Shredded Wheat**
4. **Poached Egg**
5. Bacon
6. **Toast**

7. **Tomato Juice**
8. ———
9. ***Baked Haddock Fillets—Lemon**
10. Plain Baked Haddock Fillets
11. **Whole Potatoes with Cream Pimiento and Parsley Sauce**
12. Whipped Potatoes
13. **Fresh Lima Beans or Squash**
14. Diced Summer Squash
15. **Cucumber Sticks—Radishes**
16. ———
17. ***Chocolate Pudding, Whipped Cream**
18. Chocolate Pudding, Whipped Cream
19. Lemon Gelatin Cubes
20. Half Grapefruit
21. Essence of Celery Soup

22. ***Vegetable Soup**
23. **Saltines**
24. ***Tuna Fish Salad Roll—Potato Chips**
25. Creamed Tuna Fish—Green Beans
26. Low Fat Tuna on Lettuce—Green Beans
27. Baked Potatoes
28. ———
29. **Celery Curls and Radishes**
30. ———
31. **Blueberry Tarts**
32. Fresh Applesauce
33. *Chocolate Pudding
34. Fresh Blueberries
35. Orange Juice
36. ———

August 4

1. **Sliced Oranges**
2. Orange Juice
3. **Corn Flakes or Oatmeal**
4. **Soft Boiled Egg** (Omit on Low Fat Diet)
5. Bacon
6. **Raisin Toast**

7. **Consomme**
8. **Crisp Crackers**
9. ***Ham Loaf**
10. *Roast Beef
11. **Mashed Sweet Potatoes**
12. Riced Potatoes
13. **Kale with Lemon**
14. Carrot Rings
15. **Apricot au Natural Salad**
16. ***French Dressing**
17. ***Pineapple Chiffon Pie**
18. *Jelly Roll
19. Whipped Cherry Gelatin
20. Seedless Grapes
21. Mixed Citrus Juice

22. ***Cream of Tomato Soup**
23. **Melba Toast**
24. **Braised Short Ribs—Baked Noodles**
25. Broiled Lamb Pattie
26. Broiled Lamb Pattie
27. Noodles Baked in Broth
28. **Green Peas**
29. **Tossed Salad**
30. **Oil-Vinegar Dressing**
31. **Fruit Plate-Nectarine, Plum and Grapes**
32. Canned Peeled Apricots
33. Soft Custard
34. Fresh Plums
35. Grapeade
36. **Frosted Raisin Rolls**

August 5

1. **Fresh Sliced Peaches**
2. Grapefruit Juice
3. **Farina or Wheat and Barley Kernels**
4. **Scrambled Egg**
5. Country Sausage
6. **Toast**

7. **Lime Juice Cocktail**
8. ———
9. ***Broiled Chicken**
10. *Roast Chicken
11. **New Potatoes**
12. New Potatoes
13. **Corn on Cob or Green Beans**
14. Julienne Green Beans
15. ***French Salad Bowl**
16. ———
17. **Cherry Ice Cream**
18. Vanilla Ice Cream with Canned Sliced Peaches
19. Lemon Ice
20. Fresh Fruit Cup
21. Beef Bouillon

22. ***Split Pea Soup**
23. **Croutons**
24. **Cheese Croquettes with Jelly—Crisp Bacon**
25. Crisp Bacon
26. Cold Roast Beef
27. Baked Potatoes
28. **Spinach with Lemon**
29. **Sliced Orange Salad**
30. **French Dressing**
31. **Honeydew Melon**
32. Prune Whip
33. Raspberry Rennet-Custard
34. Honeydew Melon
35. Apple Juice
36. ***Plain Muffins**

August 6

1. **Tomato Juice**
2. Tomato Juice
3. **Crisp Rice Cereal or Granular Wheat Cereal**
4. **Poached Egg**
5. Canadian Bacon
6. **Toast**

7. **Jellied Broth**
8. **Saltines**
9. ***Rolled Flank Steak with Dressing**
10. Broiled Cubed Flank Steak
11. **Mashed Potatoes**
12. Whipped Potatoes
13. ***Harvard Beets**
14. Asparagus Tips
15. **Cucumber and Onion Slices in Tart Vinegar**
16. ———
17. ***Apple Cobbler, Brown Sugar Sauce**
18. *Butterscotch Pudding, Whipped Cream
19. Cherry Sponge
20. Fresh Apricots
21. Grapefruit Juice

22. ***Creole Soup**
23. **Crisp Crackers**
24. **Salad Plate—*Jellied Cottage Cheese Mold, Lettuce Cups with Melon Balls, Sliced Bananas, Bing Cherries, Apricot Halves**
25. Pear and Cottage Cheese Salad—Peas
26. Sliced Chicken—Peas
27. Potato Balls
28. ———
29. **Celery Hearts**
30. ———
31. ***Date Sandwich Cake, Whipped Cream**
32. Royal Anne Cherries
33. Baked Custard
34. Bing Cherry and Orange Cup
35. Fruitade
36. **Buttered Raisin Bread Toast**

August 7

1. **Orange Juice**
2. Orange Juice
3. **Rolled Wheat or Crisp Oat Cereal**
4. **Scrambled Egg** (Omit on Low Fat Diet)
5. Bacon
6. **Toast**

7. **Beef Bouillon**
8. **Celery Crackers**
9. ***Roast Leg of Veal**
10. Roast Leg of Veal
11. **Potatoes au Gratin**
12. Parslied Lattice Potatoes
13. ***Baked Zucchini**
14. Sliced Carrots
15. **Molded Bing Cherry and Cress Salad**
16. **Cream Mayonnaise**
17. **Warm Orange Marmalade—Bread Pudding**
18. *Bread Pudding—Jelly
19. *Cranberry Ice
20. Fresh Plums
21. Blended Citrus Juice

22. ***French Onion Soup**
23. **Rye Cheese Croutons**
24. ***Italian Spaghetti**
25. Baked Beef Pattie
26. Baked Beef Pattie
27. Spaghetti with Tomato Puree
28. **Whole Green Beans**
29. **Mixed Green Salad Bowl**
30. **Vinegar-Oil Dressing**
31. ***Sponge Cake, Sliced Peaches Atop, Whipped Cream**
32. Stewed Peaches—Sponge Cake
33. Apricot Nectar Mold
34. Sliced Fresh Peaches
35. Pineapple Juice
36. **French Bread**

August 8

1. **Banana**
2. Blended Citrus Juice
3. **Puffed Wheat or Oatmeal**
4. **Soft Cooked Egg**
5. Bacon
6. **Crumb Buns**

7. **Consomme Madrilene**
8. **Toasted Crusts**
9. ***Baked Ham**
10. Pot Roast of Beef
11. **Fluffy Mashed Potatoes**
12. Baked Potatoes
13. **Green Cabbage**
14. Mashed Squash
15. **Pineapple and Chicory Salad**
16. ***Golden Pineapple Dressing**
17. ***Lemon Sponge Pudding**
18. *Lemon Sponge Pudding
19. Lemon Gelatin Cubes
20. Orange and Blueberry Cup
21. Orange Juice

22. ***Scotch Broth**
23. **Saltines**
24. **Creamed Chicken and Mushrooms on Rice**
25. Creamed Chicken
26. Sliced Chicken
27. Steamed Rice
28. **Green Peas**
29. **Tomato and Cress Salad**
30. ***Piquante Dressing**
31. ***Melon Balls and Raspberries**
32. Fresh Applesauce
33. Baked Custard
34. Melon Ball Cup
35. Limeade
36. **Bread**

August 9

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Rolled Wheat or Crisp Rice Cereal**
4. **Poached Egg** (Omit on Low Fat Diet)
5. Link Sausage
6. ***Sally Lunn**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Country Fried Liver—Bacon**
10. Plain Baked Liver
11. **New Potatoes, Cream Sauce**
12. New Potatoes
13. **Stewed Tomatoes and Okra**
14. Tender Beet Greens
15. **Cantaloupe Ring Fruit Salad**
16. **French Dressing**
17. **Butter Pecan Ice Cream**
18. Raspberry Ice
19. Raspberry Ice
20. Watermelon
21. Mixed Citrus Juice

22. **Chicken Noodle Soup**
23. **Crisp Crackers**
24. **Cold Cuts—*Potato Salad**
25. Minced Beef—Asparagus
26. Cold Roast Beef—Asparagus
27. Baked Sweet Potatoes
28. ———
29. **Carrot Curls and Radishes**
30. ———
31. **Baked Peach Dumpling**
32. Canned Fruit Compote
33. Vanilla Pudding
34. Fresh Plum Cup
35. Orange Juice
36. **Rye Bread**

August 10

1. **Honey Ball Melon**
2. Blended Citrus Juice
3. **Bran Flakes or Farina**
4. **Scrambled Egg**
5. Bacon
6. **Raisin Toast**

7. **Essence of Celery Soup**
8. **Saltines**
9. ***Salmon Croquettes**
10. *Poached Salmon
11. **Scalloped Potatoes**
12. Whipped Potatoes
13. **Peas and Mushrooms**
14. Fresh Spinach
15. ***Perfection Salad**
16. **Cream Mayonnaise**
17. ***Cherry Pie**
18. *Boston Cream Pie
19. Assorted Gelatin Cubes
20. Bing Cherries
21. Apricot Nectar with Lemon

22. ***Southern Bisque**
23. **Toasted Bread Sticks**
24. ***Shrimp Creole in Rice Ring**
25. Sliced Cheese Sandwich
26. Cottage Cheese
27. Baked Stuffed Potatoes
28. **Whole Green Beans**
29. **Tossed Salad**
30. **Vinegar-Oil Dressing**
31. **Snow Pudding, Sugared Diced Oranges**
32. Snow Pudding, Sugared Orange Sections
33. Snow Pudding—*Custard Sauce
34. Diced Orange Cup
35. Grapefruit Juice
36. **Cloverleaf Rolls**

August 11

1. **Sliced Banana in Orange Juice**
2. Orange Juice
3. **Granular Wheat Cereal or Corn Flakes**
4. **Poached Egg** (Omit on Low Fat Diet)
5. Grilled Ham
6. ***Coffee Cake**

7. **Mushroom Bouillon**
8. **Toasted Crackers**
9. ***Beefsteak Pie**
10. Plain Meat Balls
11. ———
12. Parslied Lattice Potatoes
13. **Baked Acorn Squash**
14. Baked Acorn Squash
15. **Lettuce Wedge Salad**
16. ***Russian Dressing**
17. **Fresh Pear and Grapes**
18. Banana Chocolate Pudding
19. Grape Sponge
20. Fresh Pear and Grape Cup
21. Limeade

22. ***Corn Chowder**
23. **Saltines**
24. **Open Sliced Cheese, Lettuce and Tomato Sandwich**
25. Scrambled Eggs-Peas
26. Baked Veal Chop-Plain Broiled Tomato
27. Noodles
28. ———
29. **Cabbage and Green Pepper Salad**
30. **Cream Mayonnaise**
31. **Raspberry Whipped Cream Sponge Cake Roll**
32. Royal Anne Cherries
33. Vanilla Ice Cream
34. Diced Melon Cup
35. Blended Citrus Juice
36. ———

August 12

1. **Tomato Juice**
2. Tomato Juice
3. **Shredded Wheat or Hominy**
4. **Soft Cooked Egg**
5. Bacon
6. **Toast**

Around the Wards with Kellogg's

Patient CLARK De-licious! My favorite breakfast to make me feel right at home! (Right! Kellogg's cereals are a tasty treat. Kellogg's cereals are favorites with kids and grown-ups the country over.)

Nurse DOUGHERTY I don't know what I'd do without Kellogg's Individuals. They save me time—there's a choice for everyone—and what a cinch to serve!

Dietitian BROWN Breakfast planning is so much easier with Kellogg's big assortment of flakes, shredded and popped cereals. And they're healthful too—all either are made from the whole grain or are restored to whole grain levels of thiamine, niacin and iron!

KELLOGG'S NEW INDIVIDUAL PACKAGE IS EASY TO USE *2 WAYS!*

Just take the box in both hands and break open the top along the perforated line as shown. That's all there is to it! A perfect portion every time! (And for extra fun, eat right out of the package—just open the little perforated doors on the back of the box and pour the milk right on!) Either way, Kellogg's new Individual Box is CONVENIENT FOR YOU!

KELLOGG'S CORN FLAKES • RICE KRISPIES • PEP • KELLOGG'S 40% BRAN FLAKES • CORN-SOYA
KRUMBLES • KELLOGG'S SHREDDED WHEAT • KELLOGG'S RAISIN BRAN FLAKES • ALL-BRAN

7. **Consomme a la Royal**
8. **Saltines**
9. ***Roast Turkey-Cranberry Jelly**
10. Roast Turkey
11. **Mashed Potatoes**
12. Whipped Potatoes
13. **Cauliflower or Carrots**
14. Quartered Carrots
15. **Cress and Radish Salad**
16. **French Dressing**
17. **Fresh Peach Sundae**
18. Vanilla Ice Cream
19. Orange Ice
20. Fresh Plums
21. Raspberry and Lemon Nectar

22. ***Cream of Mushroom Soup**
23. **Melba Toast**
24. **Fruit Salad-Sliced Pineapple, Pear with Cheese, Coconut, Red Raspberry, Grapefruit Sections-*Banana Bread Sandwich**
25. Lamb Pattie-Broiled Pear with Jelly-Asparagus
26. Lamb Pattie-Asparagus-Celery Hearts
27. Potato Balls
28. ———
29. ———
30. ———
31. ***Chocolate Chip Pie or Baked Custard**
32. Canned Peeled Apricots
33. Baked Custard
34. Fresh Fruit Cup
35. Mixed Fruit Juice
36. ———

August 13

1. **Orange Juice**
2. Orange Juice
3. **Oatmeal or Puffed Rice**
4. **Scrambled Egg** (Omit on Low Fat Diet)
5. Link Sausage
6. **Cinnamon Muffins**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Hamburgers**
10. Plain Baked Veal Pattie
11. **Savory Stuffed Potatoes**
12. Baked Potatoes
13. **Corn on Cob or Green Beans**
14. Whole Green Beans
15. ***Cucumber Relish**
16. ———
17. **Crackers-Cheese-Guava Jelly**
18. Crackers-Cheese-Guava Jelly
19. Apricot Nectar Mold
20. Sliced Fresh Peaches
21. Grapefruit Juice

22. **Family Style Turkey Soup**
23. **Crisp Crackers**
24. ***Spanish Rice Crisp Bacon**
25. Crisp Bacon
26. Cold Sliced Turkey
27. Rice with Tomato Puree
28. **Spinach, Egg Garnish**
29. **Iced Relishes**
30. ———
31. ***Warm Apple Crisp with Ice Cream**
32. Fresh Applesauce
33. Vanilla Ice Cream
34. Ribier Grapes
35. Blended Fruit Juice
36. **Swedish Rye Bread**

August 14

1. **Sliced Banana**
2. Blended Citrus Juice
3. **Corn Flakes or Granular Wheat Cereal**
4. **Poached Egg**
5. Bacon
6. **Toast**

7. **Tomato Juice**
8. ———
9. **Roast Pork-Applesauce**
10. Broiled Cubed Steak
11. **Hominy**
12. Riced Potatoes
13. **Turnip Greens**
14. Diced Beets
15. **Cabbage, Carrot and Nut Salad**
16. **Tarragon Dressing**
17. ***Devil's Food Pudding**
18. Jellied Canned Fruit
19. Lemon Ice
20. Half Grapefruit
21. Beef Bouillon

22. ***Vegetable Soup**
23. **Saltines**
24. **Creamed Dried Beef and Mushrooms on Chinese Noodles**
25. Canned Peach and Cottage Cheese Salad
26. Cottage Cheese on Lettuce
27. Baked Potatoes
28. **Green Peas**
29. **Fresh Peach Cup Salad**
30. **French Dressing**
31. **Honeydew Melon, Lime Wedge**
32. Prune Whip
33. Floating Island
34. Honeydew Melon
35. Orange Juice
36. **Bread**

August 15

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Farina or Shredded Wheat**
4. **Scrambled Egg** (Omit on Low Fat Diet)
5. Country Sausage
6. **Toast**

7. **Consomme**
8. **Crisp Crackers**
9. ***Spiced Liver or Beef Pot Roast**
10. Broiled Liver
11. **Browned Potatoes**
12. New Potatoes
13. **Stewed Fresh Tomatoes**
14. Butternut Squash
15. ***Pepper Relish Salad**
16. ***Mayonnaise**
17. ***Coconut Custard Pie**
18. *Baked Custard
19. Assorted Gelatin Cubes
20. Orange and Grape Cup
21. Apricot Nectar with Lime Juice

22. ***Split Pea Soup**
23. **Croutons**
24. **Tossed Vegetable Salad with Julienne Meat—Stuffed Celery**
25. Minced Beef—Carrot Balls
26. Diced Beef—Carrot Balls —Celery Hearts
27. Riced Potatoes
28. ———
29. ———
30. ———
31. **Blueberries—Thin Cream**
32. Sliced Banana in Orange Juice
33. Baked Custard
34. Fresh Blueberries
35. Apple Juice
36. ***Corn Muffins**

August 16

1. **Orange Halves**
2. Orange Juice
3. **Wheat Flakes or Oatmeal**
4. **Soft Cooked Egg**
5. Bacon
6. ***Scotch Scones**

7. **Beef Bouillon**
8. **Melba Toast**
9. **Turkey a la King on Rice**
10. Hot Sliced Turkey
11. ———
12. Parslied Potatoes
13. **Corn on Cob**
14. Asparagus Tips
15. **Celery and Olives**
16. ———
17. **Raspberry Sherbet**
18. Raspberry Sherbet
19. Raspberry Ice
20. Fresh Fruit Cup
21. Grapefruit Juice

22. **Cream of Turkey Soup**
23. **Croutons**
24. **Grilled Ham—Mashed Sweet Potatoes with Marshmallow**
25. Baked Lamb Pattie with Bacon Wrap—Spinach
26. Baked Lamb Pattie—Spinach
27. Mashed Sweet Potatoes
28. ———
29. **Cabbage and Green Pepper Slaw**
30. **Sour Cream Dressing**
31. **Watermelon**
32. Stewed Peach and Bing Cherry Compote
33. Cherry Gelatin Cubes, Custard Sauce
34. Watermelon
35. Pineapple Juice
36. ***Blueberry Muffins**

August 17

1. **Fresh Bing Cherries**
2. Tomato Juice
3. **Granular Wheat Cereal or Puffed Rice**
4. **Poached Egg** (Omit on Normal and Low Fat Diets)
5. Link Sausage
6. **French Toast—Syrup**

7. **Essence of Vegetable Soup**
8. **Whole Wheat Wafers**
9. **Broiled White Fish—Lemon Butter**
10. Broiled White Fish—Lemon Wedge
11. **Potatoes au Gratin**
12. Cubed Potatoes
13. **Hot Spiced Beets**
14. Sliced Beets
15. **Jellied Raw Vegetable Salad**
16. **Mayonnaise**
17. ***Lemon Chiffon Pie**
18. Lemon Chiffon Pudding
19. Grape Sponge
20. Grapefruit Sections
21. Orange Juice

22. ***Cream of Potato Soup**
23. **Crisp Crackers**
24. **Olive Creole Omelet**
25. Cheese Omelet
26. Plain Omelet
27. Stuffed Baked Potatoes
28. **Frenched Green Beans**
29. **Head Lettuce Salad**
30. **French Dressing**
31. ***Fruit Punch—*Chocolate Cookies**
32. Canned Pears
33. Baked Custard
34. Pear and Red Plum Cup
35. Fruit Juice (Omit on High Calorie Diet
36. **Hard Rolls**

August 18

1. **Cantaloupe**
2. Prune Juice with Lemon
3. **Wheat and Barley Kernels or Farina**
4. **Scrambled Eggs** (Omit on Low Fat Diet)
5. Bacon
6. **Toast**

7. **Consomme**
8. **Saltines**
9. **Brisket of Corned Beef**
10. Broiled Cubed Steak
11. **Boiled Potatoes**
12. Baked Potatoes
13. **Green Cabbage Wedge**
14. Sliced Carrots
15. ***Waldorf Salad**
16. ———
17. ***Creamy Rice Pudding, Strawberry Hard Sauce**
18. Creamy Rice Pudding
19. Strawberry Gelatin
20. Orange and Banana Cup
21. Limeade

22. ***Spring Soup**
23. **Crisp Crackers**
24. ***Jellied Veal Loaf—Stuffed Egg Half—Cress**
25. Creamed Diced Veal—Peas
26. Baked Veal Chop—Peas
27. Riced Potatoes
28. ———
29. **Chilled Tomato Slices**
30. ———
31. **Fresh Fruit Cup with Blueberries**
32. Orange Sections and Banana Cup
33. Vanilla Ice Cream
34. Fresh Blueberries
35. Apricot Nectar
36. **Orange and Raisin Rolls**

August 19

1. **Banana**
2. Grapefruit Juice
3. **Rolled Wheat or Crisp Rice Cereal**
4. **Poached Egg**
5. Canadian Bacon
6. **Raisin Toast**

7. **Cranberry and Orange Juice**
8. **Crisp Crackers**
9. **Baked Chicken**
10. Roast Chicken
11. **Mashed Potatoes**
12. Whipped Potatoes
13. **Paprika Cauliflower**
14. Acorn Squash
15. **Iced Relishes**
16. ———
17. **Caramel Ice Cream**
18. Caramel Ice Cream
19. Lime Ice
20. Watermelon Cubes
21. Beef Bouillon

22. ***Pepper Pot Soup**
23. **Saltines**
24. **Macaroni Salad—Sliced Bologna**
25. Macaroni and Cheese—Latticed Beets
26. Cold Corned Beef—Stewed Celery
27. Macaroni (Omit on Soft Diet)
28. ———
29. **Chilled Latticed Beets**
30. ———
31. **Compote of Italian Prunes**
32. Fresh Applesauce
33. Chocolate Blanc Mange
34. Sliced Orange
35. Blended Citrus Juice
36. ***Baking Powder Biscuits —Honey**

August 20

1. **Tomato Juice**
2. Tomato Juice
3. **Wheat Shreds or Hominy**
4. **Soft Cooked Egg** (Omit on Low Fat Diet)
5. Bacon
6. **Toast**

7. **Consomme**
8. **Melba Toast**
9. **Broiled Ham**
10. Roast Beef
11. **Creamed Quartered Potatoes**
12. Riced Potatoes
13. **Frenched Green Beans**
14. Frenched Green Beans
15. ***Jellied Carrot and Pineapple Salad**
16. **Cream Mayonnaise**
17. **Blueberry Deep-Dish Pie**
18. Jellied Orange Sections
19. Orange Gelatin
20. Bing Cherries
21. Grapefruit Juice

22. ***Cream of Celery Soup**
23. **Toasted Crusts**
24. **Stuffed Green Pepper, Melted Cheese Topping**
25. Cold Sliced Chicken
26. Cold Sliced Chicken
27. Parslied Potatoes
28. **Julienne Carrots**
29. **Honeydew and Melon Ball Salad**
30. **French Dressing**
31. ***Chocolate Pudding, Whipped Cream and Slivered Chocolate**
32. Cherry Sponge
33. Cherry Sponge
34. Fresh Pear
35. Orange Juice
36. **Bread**

August 21

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Oatmeal or Puffed Wheat**
4. **Scrambled Egg**
5. Bacon
6. ***Cinnamon Buns**

7. **Jellied Broth, Lemon Slice**
8. **Saltines**
9. **Deep-Dish Veal and Vegetable Pie, Flaky Crust**
10. Roast Veal Loin
11. ———
12. Parslied Potatoes
13. **Broccoli**
14. Sliced Beets
15. **Tomato Cress Salad**
16. **French Dressing**
17. **Cantaloupe a la Mode**
18. Vanilla Ice Cream
19. Apricot Ice
20. Cantaloupe Slices
21. Blended Citrus Juice

22. ***Mulligatawny Soup**
23. **Crisp Crackers**
24. ***Potato Salad—Cold Cuts —Dill Pickle**
25. Minced Beef—Mashed Summer Squash
26. Cold Roast Beef—Plain Broiled Tomato
27. Baked Potatoes
28. ———
29. **Iced Celery Curls and Radish Roses**
30. ———
31. ***Apple Tapioca, Whipped Cream, Chopped Walnuts**
32. Apple Tapioca
33. Vanilla Ice Cream
34. Sliced Fresh Peaches
35. Pineapple Juice
36. **Pumpernickle Bread**

August 22

1. **Sliced Bananas in Orange Juice**
2. Orange Juice
3. **Corn Flakes or Granular Wheat Cereal**
4. **Poached Egg** (Omit on Low Fat Diet)
5. Grilled Ham

To get AHEAD, use HANDS—the HOBART way

The case for up-to-date food and kitchen machines is just this simple. Let's say that these are skillful hands. How long will it take them to cut up a side of beef, for example—to peel a bushel of potatoes—to wash and sanitize your dishes? Plenty—figured in time and money, both! But use these hands with modern power equipment and they'll cut, slice, chop or tenderize the meat; peel the potatoes; and wash the dishes in a mere fraction of the time. They'll handle these and many other food preparing assignments quicker and better, with less spoilage and waste, with uniformity and efficiency—and then pass on to other tasks.

The case for HOBART products is just as simple. Consider the machines themselves, with unmatched *cleanness in design* and *cleanness in performance*—with a universally recognized name for quality and endurance. Consider the unparalleled completeness of the line, allowing the most efficient individual installations. And consider the Hobart organization behind them, no further from you than your phone.

Through the ups and downs of more than a half-century, the food service industry has found that Hobart and Hobart products have supported it to the hilt. To anticipate tomorrow's problems, talk things over with Hobart today.

Choose Hobart—and the Model Built for YOU

DISHWASHERS • GLASSWASHERS • MIXERS • PEELERS • FOOD SLICERS • FOOD CUTTERS • MEAT CHOPPERS • MEAT SAWS • TENDERIZERS • COFFEE MILLS • SCALES

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Hobart *Food Machines*

THE HOBART MANUFACTURING COMPANY • TROY, OHIO

The World's Largest Manufacturer of Food and Kitchen Machines

6. **Toast**

7. **Beef Bouillon**
8. **Toasted Crusts**
9. **Baked Pork or Lamb Chop**
10. Plain Baked Lamb Pattie
11. **Parslied New Potatoes**
12. Whipped Potatoes
13. **Okra Creole or Peas**
14. Green Peas
15. **Dolly Varden Salad (Fresh Pear and Plum)**
16. **French Dressing**
17. **Lemon Snow Pudding—*Custard Sauce**
18. Lemon Snow Pudding—Custard Sauce
19. Lemon Snow Pudding
20. Pear and Plum Cup
21. Tomato Juice

22. **Julienne Vegetable Soup**
23. **Saltines**
24. ***Baked Chicken and Noodles**
25. Hot Sliced Chicken—Wax Beans
26. Hot Sliced Chicken—Wax Beans
27. Baked Noodles in Broth
28. ———
29. **Asparagus, Pimiento Salad**
30. **French Dressing**
31. **Fresh Fruit Compote**
32. Canned Peeled Apricots
33. Soft Custard
34. Fresh Fruit Compote
35. Mixed Fruit Juice
36. **Cloverleaf Rolls**

August 23

1. **Fresh Plums**
2. Blended Citrus Juice
3. **Farina or Bran Flakes**
4. **Scrambled Egg**
5. Bacon
6. ***Bran Muffins**

7. **Consomme**
8. **Crisp Crackers**
9. ***Old-Fashioned Beef Stew**
10. Broiled Cubed Steak
11. **Potatoes** (In Stew)
12. Steamed Rice
13. ***Baked Eggplant**
14. Spinach
15. ***Carolina Salad (Apple, Raisin and Cabbage)**
16. ———
17. **Fudge Cake with Coffee Ice Cream**
18. Canned Fruit Cup with Orange Ice
19. Orange Ice
20. Ribier Grapes
21. Grapefruit Juice

22. ***Spring Soup**
23. **Melba Toast**
24. **Pan Broiled Liver with Spanish Sauce—Baked Stuffed Potatoes**
25. Liver Pattie with Tomato Puree
26. Plain Baked Liver
27. Baked Potatoes
28. **Acorn Squash Rings**
29. **Orange and Blueberry Salad**
30. ***Savory Dressing**
31. **Chilled Watermelon**
32. *Angel Food Cake
33. Coffee Ice Cream
34. Watermelon Balls
35. Limeade
36. **Braided Rolls**

August 24

1. **Fresh Pear**
2. Tomato Juice
3. **Crisp Rice Cereal or Oatmeal**
4. **Soft Cooked Egg** (Omit on Low Fat Diet)
5. Canadian Bacon
6. **Toast**

7. **Grapefruit Juice**
8. ———
9. ***Pan-Fried Cod—*Tartar Sauce**
10. Plain Baked Cod—Lemon
11. **Whipped Potatoes**
12. Whipped Potatoes
13. **Corn on Cob or Asparagus**
14. Asparagus Tips
15. **Marinated Whole Green Bean, Diced Onion and Celery Salad**
16. ———
17. ***Bavarian Cream, Sliced Peaches**
18. Bavarian Cream, Canned Sliced Peaches
19. Strawberry Gelatin Mold
20. Honey Ball Melon
21. Alphabet Consomme

22. **Cream of Vegetable Soup**
23. **Whole Wheat Crackers**
24. ***Tuna Fish Salad—Toasted Tomato and Lettuce Sandwiches**
25. Poached Salmon—Peas
26. Poached Salmon—Peas—Celery Hearts
27. Parslied Potatoes
28. ———
29. ———
30. ———
31. **Fresh Blueberries**
32. Pear Half in Strawberry Gelatin
33. Baked Custard
34. Orange and Blueberry Cup
35. Pineapple Juice
36. ———

August 25

1. **Orange Juice**
2. Orange Juice
3. **Rolled Wheat or Puffed Rice**
4. **Poached Egg**
5. Bacon
6. ***Coffee Cake**

7. **Beef Bouillon**
8. **Crisp Crackers**
9. ***Roast Fresh Ham with Dressing**
10. Baked Veal Chop
11. **Paprika Potatoes**
12. Paprika Potatoes
13. **Butternut Squash**
14. Julienne Green Beans
15. **Mixed Vegetable Salad**
16. **Herb French Dressing**
17. **Ribier Grapes**
18. *Pineapple Whip, Custard Sauce
19. Plain Pineapple Whip
20. Fresh Plums
21. Tomato Juice

22. ***Cream of Asparagus Soup**
23. **Croutons**
24. **Chopped Steak on Open Toasted Bun—Pickle Chips**
25. Broiled Chopped Steak—Sliced Beets
26. Broiled Chopped Steak—Sliced Beets
27. Fluffy Rice
28. ———
29. **Mexican Slaw**
30. **Vinegar-Oil Dressing**
31. **Fresh Applesauce *Oatmeal Cookies**
32. Fresh Applesauce
33. *Floating Island
34. Fresh Fruit Cup
35. Grapefruit Juice
36. ———

August 26

1. **Honeydew Melon**
2. Blended Citrus Juice
3. **Corn Flakes or Granular Wheat Cereal**
4. **Scrambled Egg**
5. Country Sausage
6. **Toast**

7. **Orange Juice, Mint Garnish**
8. ———
9. ***Fried Chicken**
10. Roast Chicken
11. **New Potatoes**
12. New Potatoes
13. **Sliced Carrots**
14. Spinach
15. **Molded Pineapple, Cucumber and Pecan Salad**
16. **Mayonnaise**
17. **Chocolate Ice Cream**
18. Chocolate Ice Cream
19. *Cranberry Ice
20. Fresh Pineapple
21. Beef Bouillon

22. ***Cream of Corn Soup**
23. **Saltines**
24. **Salad Bowl—Greens, Quartered Egg, Tomatoes—Peanut Butter and Bacon Sandwich**
25. Peach Half on Lettuce—Toasted Chicken Liver Sandwich
26. Cottage Cheese on Lettuce—Vegetable Macedoine
27. Baked Potatoes
28. ———
29. **Celery Curls**
30. ———
31. **Fresh Fruit Cup—Coconut Cake Squares**
32. Royal Anne Cherries
33. Chocolate Ice Cream
34. Unsweetened Grapefruit Sections
35. Peach and Lemon Nectar
36. ———

August 27

1. **Grapefruit Juice**
2. Grapefruit Juice
3. **Farina or Wheat and Barley Kernels**
4. **Poached Egg** (Omit on Normal or Low Fat Diets)
5. Bacon
6. **French Toast—Syrup**

7. **Chicken Bouillon**
8. **Saltines**
9. ***Meat Loaf—*Tomato Sauce**
10. Broiled Chopped Steak
11. **Mashed Potatoes**
12. Riced Potatoes
13. **Seven-Minute Cabbage**
14. Sliced Beets
15. **Hearts of Lettuce Salad**
16. ***Roquefort Cheese Dressing**
17. **Peach Shortcake**
18. *Baked Custard
19. Assorted Gelatin Cubes
20. Sliced Fresh Peaches
21. Limeade

22. ***Cream of Spinach Soup**
23. **Crisp Crackers**
24. **Scrambled Eggs and Noodles with Grilled Canadian Bacon**
25. Scrambled Egg—Crisp Bacon
26. Fluffy Omelet
27. Noodles
28. **Peas**
29. **Tossed Salad**
30. **French Dressing**
31. **Fresh Pear and Grapes**
32. Tinted Pear and Rice Compote
33. Baked Custard
34. Seedless Grapes
35. Orange Juice
36. ***Blueberry Muffins**

August 28

1. **Bananas**
2. Apricot Nectar and Lime Juice
3. **Crisp Corn Cereal or Rolled Wheat**
4. **Soft Cooked Egg** (Omit on Low Fat Diet)
5. Bacon
6. **Toast**

7. **Consomme**
8. **Crisp Crackers**
9. ***Baked Ham—Raisin Orange Sauce**
10. Roast Lamb
11. **New Potatoes in Cream**
12. Baked Potatoes
13. **Corn or Squash**
14. Summer Squash Rings
15. ***Philadelphia Relish**
16. ———
17. ***Lemon Meringue Pie**
18. Orange Sections with Raspberry Ice
19. Raspberry Ice
20. Sliced Oranges
21. Grapefruit Juice

22. **Tomato Juice**
23. ———
24. ***Chicken Chow Mein—Rice—Chinese Noodles**
25. Creamed Chicken
26. Hot Sliced Chicken
27. Steamed Rice
28. **Green Beans**
29. **Melon Fruit Salad**
30. **French Dressing**
31. **Peppermint Stick Ice Cream—*Chocolate Brownie**
32. *Plain Pineapple Whip
33. *Plain Pineapple Whip
34. Fresh Pear
35. Beef Bouillon
36. **Toasted French Bread**

August 29

1. **Fresh Sliced Peaches**
2. Blended Citrus Juice
3. **Oatmeal or Wheat Flakes**
4. **Baked Egg**
5. Link Sausage
6. ***Bran, Honey and Nut Muffins**

7. **Beef Bouillon**
8. **Melba Rye Toast**
9. ***Yankee Pot Roast**
10. Hot Sliced Beef
11. **Franconia Potatoes**
12. Hominy
13. **Sliced Kohlrabi or Carrots**
14. Julienne Carrots
15. **Head Lettuce Salad**
16. ***Chiffonade Dressing**
17. ***Strawberry Bavarian**
18. Mocha Sponge
19. Mocha Sponge
20. Fresh Fruit Cup
21. Orange Juice

22. **Grapefruit Juice with Orange Sherbet**
23. ———
24. ***Ham and Cornbread Shortcake**
25. Hot Cubed Veal
26. Hot Cubed Veal
27. Potato Balls
28. **Asparagus Tips**
29. **Shredded Green Cabbage Salad**
30. **Tarragon Dressing**
31. **Fresh Blueberries**
32. Sliced Bananas
33. Soft Custard
34. Unsweetened Grapefruit Sections
35. Tomato Bouillon
36. ———

August 30

1. **Persian Melon or Cantaloupe**
2. Orange Juice
3. **Shredded Wheat or Hominy**
4. **Poached Egg** (Omit on Low Fat Diet)
5. Grilled Ham
6. **Toast**

7. **Alphabet Consomme**
8. **Crisp Crackers**
9. ***Deviled Pork Chops**
10. Plain Baked Liver
11. **Scalloped Potatoes**
12. Lattice Potatoes
13. **Mashed Butternut Squash**
14. Mashed Butternut Squash
15. **Cucumber Salad**
16. **Sour Cream Dressing**
17. **Fresh Plum Cobbler**
18. *Floating Island
19. Whipped Cherry Gelatin
20. Orange and Plum Cup
21. Grapefruit Juice

22. ***Cream of Celery Soup**
23. **Saltines**
24. **Roast Beef Hash—Chili Sauce**
25. Minced Beef—Wax Beans
26. Cold Sliced Beef—Wax Beans
27. Baked Sweet Potatoes
28. ———
29. **Lettuce, Radish and Raw Spinach Salad**
30. **Vinegar-Oil Dressing**
31. ***Angel Food Cake with Sliced Peaches and Whipped Cream**
32. Canned Peach—Angel Food Cake
33. *Floating Island
34. Sliced Peaches
35. Limeade
36. **Swedish Rye Bread**

August 31

1. **Orange Halves**
2. Grapefruit Juice
3. **Farina or Bran Flakes**
4. **Scrambled Egg**
5. Crisp Bacon
6. **Raisin Toast**

7. **Essence of Celery Soup**
8. **Whole Wheat Wafers**
9. **Golden Crusted Ocean Perch Fillets**
10. Broiled Ocean Perch
11. **Fluffy Mashed Potatoes**
12. Riced Potatoes
13. **Corn on Cob or Beet Greens**
14. Tender Beet Greens
15. **Raw Vegetable Salad Bowl**
16. **Thousand Island Dressing**
17. **Deep-Dish Apple Pie**
18. *Bread Pudding
19. *Grape-Juice Jelly
20. Honeydew Melon
21. Apricot Nectar and Lime Juice

22. ***Potage Printanier**
23. **Crisp Crackers**
24. ***Egg Cutlet—Parsley Sauce**
25. Cottage Cheese on Lettuce
26. Cottage Cheese
27. Baked Potatoes
28. **Green Peas**
29. **Tomato Salad**
30. **French Dressing**
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32. Jellied Canned Fruit
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Total solids	30.6%
Protein	28.3%
Fat	0.75%
Cholesterol	.07%
Sodium	70 mg.%
Iodine	17 mcg.%
Fluorine	20 ppm
Riboflavin	116 mcg.%
Niacin	13.7 mg.%
Animal Protein Factor (B_{12})	12 mcg.%
(122 calories per 100 grams)	

WELL PROPORTIONED combination of all essential amino acids (Values given as percent of protein)	
Arginine	5.2
Histidine	5.7
Isoleucine	4.7
Leucine	7.0
Lysine	8.3
Methionine	2.8
Phenylalanine	3.5
Threonine	4.1
Tryptophan	1.1
Valine	5.2

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Safety, thrift and comfort with thermal insulation

HAROLD L. LEVINSON

IN LINE WITH these times, overshadowed with controls and the threat of possible shortages, the hospital administrator and engineer might do well to examine the problem of fuel conservation.

All during the last war, the federal government endorsed insulation as an important means of conserving the nation's natural resources in addition to conserving the manpower and transportation facilities required to produce and to deliver fuel.

Should the armed forces expand still more, it follows that the supply of fuel will become less and less, and despite the fact that hospitals have a top priority in fuel allocation, the administrator cannot fully rely upon this situation's remaining static.

The question of fuel conservation is one which should be considered seriously, and thermal insulation can be a possible solution to the problem.

INSULATION MEANS COMFORT

The two primary functions of insulation are that it prevents an abnormal loss of heat from within the building and that it keeps heat from entering the building. The hospital engineer knows that insulation prevents condensation and keeps expansion and contraction of the building at a minimum.

Insulation also directly affects the patient. Uninsulated walls are sometimes as much as 11 degrees colder than the air temperature of the room. All heat, including that generated by the human body, flows to these cold wall surfaces. This produces a sense of discomfort in patients whose well-being is already at a low level.

The application of insulation to exposed elements, such as roofs, ceilings and walls, and the use of double glazing or of storm windows can help reduce the heat requirements of a building.

The Colbert County Hospital at Sheffield, Ala., a 63-bed hospital, found that the top floor rooms were extremely hot and uncomfortable during the summer months. Physicians, nurses, and patients suffered in the heat that radiated down from the roof. The operating rooms, situated on the top floor, were almost unbearably hot.

During the winter, heating became a problem. They found that during severe cold weather there usually was a temperature difference of 10 to 15 degrees between the main building and the nurses' home 75 feet away.

The hospital's board decided that insulation was the answer to these problems and had the area between the roof and the top floor ceiling covered with a four-inch layer of mineral wool at a cost of $900. The results were noteworthy.

The insulation brought summer temperatures of the top floor rooms to within two or three degrees of the rest of the building. Fuel consumption was reduced to 25 per cent and the nurses' home brought to the same temperature as the main building without excess firing of the heating plant. In addition, the top floor rooms were in constant demand by patients and at a higher rate than any others in the hospital.

By figuring the fuel savings, the increased room occupancy on the third floor, and the higher room rates charged on this floor, the hospital was able to determine that *a return of 33 1/3 per cent was being realized and that the savings would amortize the cost of the insulation in three years.*

The Washington County Hospital in Hagerstown, Md., a 158-bed institution, selected a fireproof cement-bound fiber shaving block as its insulation material. By so insulating and by putting in double glazing, it became possible for the hospital to reduce the radiation and pipe sizes.

This saving in radiation, piping and boiler capacity, did much to offset the additional cost of insulation and the remainder of the extra expense was made up in fuel savings in the *first two heating seasons.*

This hospital also found that insulation had a double-barreled effect. Tests showed that, during the summer months, insulated rooms in the new wing of the hospital averaged as much as 8 degrees cooler than the outside temperatures.

AIR CONDITIONING AFFECTED

Not only is insulation needed to save fuel, but it is an important factor in the installation of an air conditioning system. Efficient insulation pares down the size of projected air cooling equipment, for full insulation can make interiors as much as 15 degrees cooler on hottest days. Thus, with the winter fuel savings and the fact that most insulating materials are excellent fire retardants, also stands the element of decreased operational expenses.

All granular, fibrous or cellular materials have insulating properties. Insulation depends upon the insulating quality of air itself. To

Mr. Levinson is a member of the editorial staff of HOSPITALS.

The Engineering and Maintenance department is edited by Roy Hudenburg, secretary of the Council on Hospital Planning and Plant Operation.

work efficiently, air must be confined into small pockets so that convection currents are blocked. Good insulation must then do two things: (1) It must lock the air in small spaces or pockets so that convection currents are blocked, and (2) it must leave only a little of the insulating material running parallel to the direction of the heat flow.

In general, anything added to increase the stiffness or strength of the insulating material tends to decrease its effectiveness. Where insulation is compressed or binder is added, this decreases the amount of air spaces, the primary insulating factor.

CHOOSING INSULATION

No one set of recommended thickness of insulation will work for every installation. For instance, mineral wool is the industry's name for both rock wool and glass wool. Installed in the same thickness, either by hand or by the pneumatic process, they offer about the same insulating qualities. Generally, the insulating values of many fibrous materials such as mineral wool, shredded wood, cotton or other vegetable fiber and paper or cellulose insulation are about the same.

According to one manufacturer, the important points to consider when choosing insulation are: (1) Low thermal conductivity; (2) inherent resistance to moisture; (3) light weight; (4) sterility; (5) freedom from odor; (6) ease of fabrication; (7) fit of joint, insulation to insulation, and insulation to framing; (8) load-bearing characteristics, including resilience and resistance to compression even when wet; (9) sizes and forms available; (10) permanence of form, and (11) final cost installed in equipment, as measured by the life of the equipment and taking all other factors into consideration.

It is important to remember that, in existing buildings, the addition of thermal protection will change the temperature conditions which formerly existed in the structure.

TYPES OF INSULATION

There are numerous kinds of insulating materials for the administrator to consider. It is improper to speak of one insulating material as more "efficient" than another. Insulating materials do differ from each other in conductivity for heat, but it is only necessary to install a correspondingly greater thickness of one with a higher conductivity in order to attain a given insulating effect.

Insulating materials fall into two groups, the first composed of those having a low density and comparatively low conductivity. These materials resist the passage of heat by conduction. The second group, which has a more limited application, comprises metallic surfaces which "box in" air spaces within the construction of walls, ceilings or roofs. These materials act as heat or infra-red ray reflectors.

The first group is divided into three classes — rigid insulation, flexible types and insulating fills. The different types of metals are used to subdivide the second group.[1]

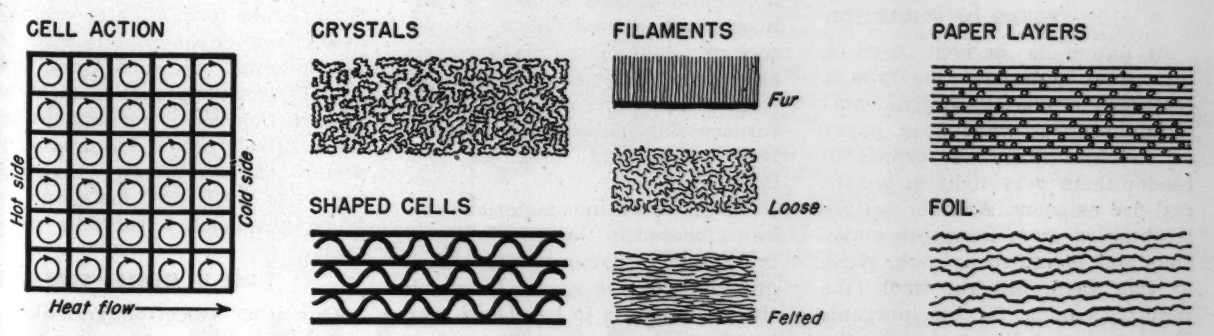
Rigid insulation is generally manufactured in the shape of boards of varying thicknesses. One variety is composed of wood, cane or other vegetable fibers which are pressed into sheets rigid enough to facilitate fastening them upon joists or studding. Pressed cork is also used in the form of sheets up to several inches in thickness. Such types of insulation are generally used as a base for plaster on ceilings or exterior walls, and some are attractively finished so that they may be used on exposed interior surfaces.

Others come with vapor seals (paper which has been waterproofed on one side) to guard against the passage of water vapor. Some manufacturers furnish boards with one face covered with aluminum foil in order to combine the functions of low heat conduction with the reflection of radiant heat. This same group includes pieces such as blocks and short boards or slabs formed of inorganic materials.

Mineral wool is available in blocks, varying in thickness from one to four inches. Pressed granulated cork also can be obtained in board form and has its particular application in roof insulation.

Flexible insulation is used as fillers between wood studs in exterior wall construction and between the joists of flat roofs. It is also used between furring strips on the inside of masonry walls and between floor or roof joists in steel-framed buildings, if provi-

ALL lightweight granular, cellular or fibrous materials have insulating properties attributable to the insulating property of air. Good insulation (1) must lock air in small pockets to retard convection and (2) must interrupt the transfer of heat by the radiation process.



—Courtesy of *Power* Magazine

KINDS AND SHAPES OF HEAT INSULATION FOR WARM SURFACES	Hair felt	Air-cell asbestos	Asbestos, fibrous	85% Magnesia	Sponge-felted asbestos paper	Mineral wool	Diatomaceous silica (calcined)	Diatomaceous silica (calcined brick)	Crumpled aluminum foil
Usual maximum temperature	200 F	300 F	750 F	600 F	700 F	1000 F	1900 F	2500 F	
Poured loose or granulated				✓		✓	✓		
Cement			✓	✓		✓			
Blankets or batts	✓	✓				✓			
Sheets (flexible)		✓	✓		✓	✓			✓
Boards or blocks (stiff)		✓	✓	✓	✓	✓	✓		
Molded segments				✓					
Shaped sections	✓	✓	✓	✓	✓	✓	✓		
Bricks								✓	

—Courtesy of *Power* Magazine

INSULATING materials can be obtained in a number of shapes and forms for power plant use. Maximum temperatures determine the type of insulation used in these installations.

sion has been made for its attachment.

FORMS OF INSULATION

Insulation is derived from a myriad of materials. One type is composed of various organic materials, such as wood fiber, paper or cellulose fiber, all treated to render them very light in weight and fire resistant. Another variety is obtained from inorganic materials and identified as rock, glass, or slag wool. Mineral wool (the industry's name for the inorganic fibrous materials) comes in the form of fine, interlaced, resilient fibers. Composed principally of silicates of calcium and aluminum, it resembles loose wool or cotton. Rock wool is made from natural rock or a combination of limestone and shale. Slag wool is derived from iron, copper, or lead blast-furnace slag. Glass wool is made from silica sand, soda ash and limestone.

These insulating materials can be purchased in the form of batts or blankets, whichever may be required to fit the spaces in which the insulation is to be placed. The usual thickness is two or four inches, and the insulation is often covered on one side with a vapor seal.

Insulating fills are furnished in a granular form, often in the shape and size of small pellets. Several of the varieties, particularly those which are made from expanded mica and diatomaceous earth, are used for hand-packing narrow sections around doors, window frames and other irregular surfaces. They are frequently used in high temperature insulation. Mineral and glass wools can be obtained in loose form for hand-packing if required. A disadvantage of "loose fills" is that one never knows if he has a *complete* fill in the space receiving this insulating material.

Wooden, cement, and composition shingles, roofing paper, tar papers, and building papers are not ordinarily considered to be thermal insulators. Such material may reduce heat loss by air leakage, but their effect on the heat loss by conduction is not great.

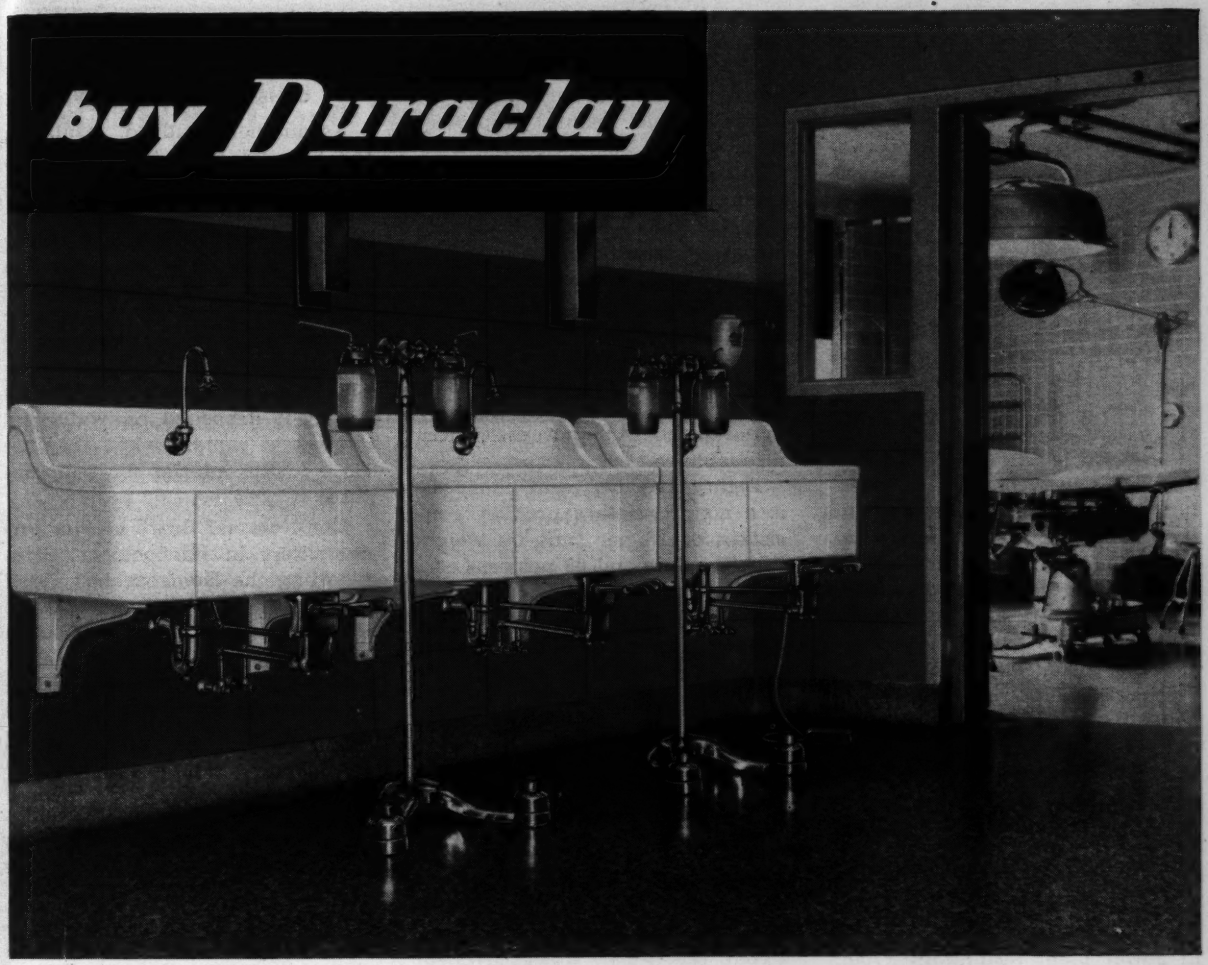
Reflective insulation materials are generally found in the form of foil mounted on paper or else in thin metal sheets. If installed as continuous surfaces, they also provide an excellent vapor seal. Aluminum foil mounted upon a strong paper backing is a popular insulator. Thin sheets of steel are used but the disadvantage here is that if oxidation occurs on the surface, the bright reflecting surface is rendered useless as insulating material.

Reflective insulation has one advantage in that it acts as an effective vapor barrier. Reflective sheets probably require more care and skill in handling and installation, thus increasing the cost.

The rigid, flexible and reflective types are used quite often in exterior wall structure. The flexible types, in the form of batts or blankets composed of organic materials, minerals, or glass wool, are usually more appropriate for new construction than are loose fills. Loose fills, however, are used very widely for insulating existing buildings and are installed by blowing machines for this purpose.

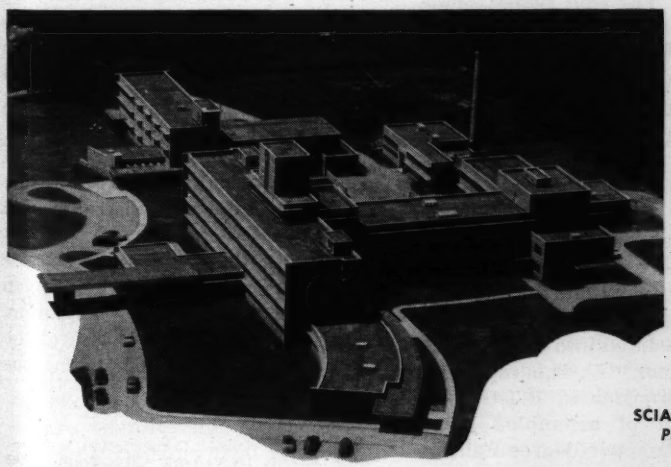
USE IN HEATED SURFACES

One other aspect of thermal insulation is that of power plant insulation, specifically boilers,



ST. FRANCES CABRINI HOSPITAL, Alexandria, La.

CHOICE OF **ST. FRANCES CABRINI HOSPITAL**



AND MANY, MANY OTHERS

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pipes, and tanks. Much fuel is wasted in boiler and furnace rooms simply because this equipment is either not sufficiently insulated or else is not insulated at all. Insulating cold water pipes to keep condensation from collecting is as important as insulating the hot water pipes.

RADIATION LOSS

The radiation loss from steam heated surfaces is one of the most easily determined losses in the power plant. A square foot of ordinary bare pipe will radiate approximately three B.T.U.'s per square foot per hour per degree difference between the temperature of the steam in the pipe and the outside or room temperature. Insulation will reduce this loss by from 75-90 per cent depending upon the quality and thickness of the insulation[2].

In one instance in a hotel building, the insulation of boiler doors, boiler drums, steam water heater and a 40-pound steam line resulted in a saving of $1,400 per year and paid for the costs of the insulation in 18 months.

HEAT INSULATORS

There are a number of different types of insulating materials used in power plant insulating: Fibers of hair and wool can be felted (loosely interlaced) and this felt can be formed into sectional pipe covering blocks or into sheets which are pliable enough to enable fitting them over curved or irregular surfaces. This organic insulation should not be used at temperatures that range above 200° F.

A low cost asbestos air cell (layers of corrugated asbestos paper) is used chiefly on domestic steam and hot water lines—rarely for permanent industrial lines. Asbestos air cells are seldom used over 300° F.

Asbestos fibers may be "felted" to form sheets or blocks or pipe covering. Again, it is important to remember that these shapes can be made stiffer and stronger by adding binder, but always at the expense of some loss in the efficiency of the insulation. The same holds true of asbestos cement. The greater its cementing quality, the poorer its insulating quality. Thus soft cements of high insulating quality are commonly given a thin finishing coat of hard-finish cement, applied mainly as protection.

Mineral wool is made by exposing a thin stream of molten slag (or glass) to a high velocity steam jet, resulting in a substance resembling a woolly mass of tangled mineral fibers. In this form—poured loose, or laid out flat as a batt or blanket—it has high insulating efficiency. It is important to note that this type of insulating material should be purchased from a reliable concern.

Eighty-five per cent magnesia is a nonproprietary product, consisting of 15 per cent by weight asbestos fiber and 85 per cent carbonate of magnesia, chemically derived from dolomite rock. The insulating value of this particular material comes entirely from microscopic air spaces between the magnesia crystals. Because of its character, 85 per cent magnesia cannot be felted. It is formed by wet molding and the manufactured forms are sectional pipe covering, blocks, segments and cement. For pipe temperatures above the magnesia temperature limit of 600° F, insulation is applied in two sectional layers—an inner layer of diatomaceous silica and an outer layer of the more efficient 85 per cent magnesia. High temperature diatomaceous silica insulations are made to withstand temperatures up to 1900° F.

ESTIMATING FUEL SAVINGS

In estimating fuel savings, one can use either the average heating season temperature or degree days as a basis. Since the inside surface temperature and heat transfer of a section depend on the type, thickness, and arrangement of materials used as well as inside and outside air temperatures, the minimum and optimum temperatures can be translated into a heat transmission factor "U". This represents the heat transfer in B.T.U.'s per square foot of assembled structural sections, per degree Fahrenheit temperature difference between inside and outside air.

The "U" values for any combination can be calculated and guides for composite arrangements have been published[3].

OTHER INSULATION DIVIDENDS

As another dividend, insulating the hospital can effect a savings in decorating costs. For instance, the U. S. Bureau of Mines states: "Well recognized by mortgage lenders is the fact that insulation in side walls and ceilings reduces the number of times the interior of a house must be redecorated." This is so because dust-laden moisture does not circulate so readily nor is it deposited on walls and ceilings so rapidly when they are close to the interior air temperatures.

The National Board of Fire Underwriters in its booklet, "Safeguarding the Home against Fire," states that "figures prove that fire loss from electricity stands fifth in the list of known causes. Fires due to the wiring often break out behind walls or under floors where it is difficult to get at them. Using certain fireproof types of insulation which fill walls through which the wiring runs provides protection in two ways. It muffles sparks on overhead wiring and helps confine the damage to a local area."

National Board of Fire Underwriters' tests show that a wood lath partition completely filled with mineral wool will halt the passage of fire for one hour in what may otherwise be a natural flue. Many cases can be found where a fire starting on a roof outside a building was slowed down or completely stopped when reaching a layer of insulation installed between the roof and the top floor ceiling.

Insulation is a long range investment, worthy of consideration by the hospital administrator. The substantiated facts clearly point out that no hospital can be considered modern unless it has given full consideration to insulation. And more important, it assures the comfort and safety of both the patients and the staff.

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1. "Architectural Construction," Theodore Crane. New York City, John Wiley & Sons, Inc. 1947.

2. "Fuel Conservation in Hospitals". Manual for Power Plants. American Hospital Association. 1951.

3. Guide of the Society of Heating and Ventilating Engineers. 1947.

ENGINEERING and MAINTENANCE COMMENT

Electronic controls

SINCE THE END of the war there has been a veritable flood of literature describing new electronic control devices. Many of the new items may be capable of serving hospitals to an unusual degree.

Temperature controls: Several ingenious temperature control devices were shown at a trade exhibit in Chicago recently. One of the newest type devices (7E-1*) aids in the regulation of inside temperatures by an outside control unit. It does, in fact, meter heat to the weather.

This electronic device is, in effect, a miniature of the building. It has its own thermostat and a tiny electric heater—and the same comparative heating needs as the building. When the device is mounted in one or more positions outside of the building and exposed to the same weather conditions, it reacts in the same manner as the larger structure.

The control device, of course, is more sensitive to weather changes and thus makes it possible to provide more uniform temperatures.

A careful study of the hospital's heating demands may show that the outside control device would be practical and economical in the long run.

Electric-eye doors: The person entering the main entrance of Hartford (Conn.) Hospital's new medical building would see another new electronic device in action. These are three-quarter inch solid glass electric-eye doors (7E-2*). The doors are operated by means of a photoelectric cell.

When the ray is intercepted between the light source on one post and the photoelectric unit on the opposite post, the door opens. There is also a diagonal ray from the photoelectric cell post to a post on the opposite side of the door. The door remains open as long as the diagonal ray is intercepted. When passage through the door is completed, the door closes.

These are some of the advantages for electric-eye doors whether they are used at the main entrance or elsewhere: (1) Doors are open only while traffic is going through; (2) temperature and humidity control is simplified; (3) traffic can move faster; (4) patients and employees are not forced to shift packages, trays and bundles to open the door; (5) a wheel chair or stretcher can be brought through without delay, the doors remaining open the sufficient length of time.

In case of an emergency, both pairs of doors of the Medical Building will open outward. Should the power fail, the doors are never locked in a closed position. They are closed mechanically by the use of springs. This provision has an added safety value in the event that small children are in the path of the closing doors.

Electronic alarm systems: Photoelectric fire and smoke detection and intrusion alarm systems (7E-3*) can also serve the hospital effectively. There are numerous sources of supply for such devices. The smoke detection device should not be looked upon as a replacement but rather to augment thermal devices.

An essential application is in ventilating or air conditioning ducts. Smoke detection devices can be installed in the ducts so that the instant a pre-determined amount of smoke is present, the blower fan will be shut off and a visible or audible signal given.

The number of units that can be installed may vary from one to 100 depending upon the specific needs of the hospital. It is important that the relay box be set up so that the exact location of trouble is immediately indicated. In addition, there should be a device to signal electric failure since systems of this type function only when current is available.

Similar signaling devices are useful in those areas of the hospital which cannot be locked but where unauthorized persons are not wanted.

Ladder stabilizer

Accidents caused by slipping ladders are always serious. That is why an announcement of a new type ladder stabilizer (7E-4*) is of such general interest. The stabilizer illustrated is an adjustable steel attachment for the lower end of straight or extension ladders.

The manufacturer states that a ladder with this attachment will remain firm and steady in any position on steps, sloping terrain, curbs or driveways.

The assembly consists of two steel legs, which act as plungers in vertical tubes. Each leg has a swiveled shoe attached to its lower end by a ball-and-socket joint. Each shoe, a hardened steel plate with a diameter of 3½ inches, has a rubber and cord sole ⅜-inch thick vulcanized to it. For use on ice, soft ground or slippery asphalt, the steel plate has four sharp teeth which, when the shoe is rotated and turned flat to the ladder rails, dig into the surface.

The vertical tubes that house the legs or plungers are cross-connected near their upper ends by steel telescoping valve tubes leading to a central valve block. This permits an hydraulic adjustment of the legs. When the valve is closed, the system is locked. This attachment will support loads up to 1,000 pounds.—R. H.

*Readers desiring to know the names of the firms manufacturing or distributing the products described should address inquiries to HOSPITALS, Editorial Department, 18 E. Division Street, Chicago 10. For convenience, list the code numbers that follow the items about which information is requested.

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PERSONAL News

MILDRED H. MITCHELL has been appointed assistant superintendent of the Chicago Lying-In Hospital, a division of the University of Chicago Clinics. She succeeds FRANK R. SHANK who now is director of the Springfield (Ill.) Memorial Hospital.

MRS. MITCHELL

Mrs. Mitchell has been administrative assistant of the Chicago Lying-In Hospital since 1945.

A. KIRK BESLEY has resigned as assistant superintendent of the Western Pennsylvania Hospital, Pittsburgh, to accept the position of administrator of the Uniontown (Pa.) Hospital.

Mr. Besley previously was administrator of the Prince George's General Hospital, Cheverly, Md.

A nominee of the American College of Hospital Administrators, Mr. Besley is a personal member of the American Hospital Association, and a member of the Hospital Association of Pennsylvania and the Southwestern Hospital Conference of Pennsylvania. He is listed in "American Men of Science" and is the author of several publications.

CLELLIA B. WRIGHT, former operating room supervisor of Mercer County Hospital, Aledo, Ill., has been appointed acting superintendent of that hospital, succeeding MRS. ETHELYN B. THORNTON who resigned.

PAUL F. DETRICK has been appointed administrator of the new 91-bed Arkansas City (Kan.) Memorial Hospital.

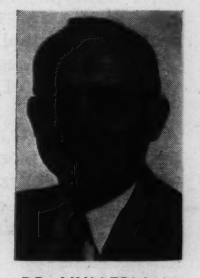
Mr. Detrick formerly was administrative resident at Bethany Hospital, Kansas City, Kan., and has completed the academic work for a master's degree in hospital administration from Northwestern University.

CHARLES C. SELLERS has been appointed assistant administrator of Emergency Hospital, Washington, D. C. During the last war, he did volunteer work in a hospital to relieve the staff shortage.

MARGUERITE B. YOUNGLOVE, formerly director of nursing at the Children's Hospital, Buffalo, N. Y., has been appointed director of nurses at Mount Sinai Hospital, Minneapolis.

Miss Younglove was a member of the Colorado State Board of Nurse Examiners and is a member of the American Nurses Association, the National League of Nursing Education, the American Association of University Women, and Altrusa International.

DR. HUGO V. HULLERMAN has resigned as assistant director of Rhode Island Hospital, Providence, R. I., to accept the position of director of hospital services with the United Hospital Fund of New York, a central fund-raising organization for 86 hospitals in New York City.



DR. HULLERMAN

Dr. Hullerman served for several years with the Illinois state public health department and the Peoria (Ill.) health department. A former assistant director of the American Hospital Association, Dr. Hullerman was also secretary of the Councils on Professional Practice, International Relations, and Education.

Dr. Hullerman is a fellow of the American Public Health Association and the American Medical Association. He is a member of the American Hospital Association, Rhode Island Hospital Association, New England Hospital Assembly, the Illinois Public Health Association, the Illinois Medical Society, and the American Trudeau Society of the National Tuberculosis Association.

GRACE V. BARBER, superintendent of Children's Memorial Hospital, Omaha, was married in April to Leon Gaskill. She will continue as superintendent of the hospital.

DWAYNE L. HALL has been appointed administrator of the Bowling Green (Ky.) City Hospital.

Mr. Hall received his bachelor's degree in business administration from the University of Denver and his master's degree in hospital administration from Northwestern University. He served his administrative residency under S. A. RUSKJER, deputy director of the Louisville and Jefferson County Board of Health, Louisville, Ky., and administrator of Waverly Hills (Ky.) Sanatorium.

MR. HALL

Mr. Hall will be administrator of the new Bowling Green-Warren County Hospital after completion of a 70-bed addition.

DR. E. D. FUNK, who has retired appointed director of the 500-bed (Pa.) Hospital, has been succeeded by DR. CLAIR G. SPANGLER.

Dr. Spangler has been on the hospital's staff since 1929 and for the last five years has been associate medical director.

DR. JOHN A. TRAUTMAN has been appointed director of the 500-bed clinical center for medical research nearing completion at the National Institutes of Health, Bethesda, Md. Dr. Trautman previously was medical officer in charge of the U. S. Marine Hospital in Staten Island, N. Y.

CAPT. ALBERT T. WALKER, former Pacific Fleet surgeon, is now in charge of the Naval Hospital at St. Albans, Queens, N. Y. He succeeds CAPT. CHARLES WILCOX, executive officer of the hospital, who has been acting commander.

ERNEST M. SABLE has been appointed assistant superintendent of

Cedars of Lebanon Hospital, Los Angeles. He formerly was assistant director at Mount Zion Hospital in San Francisco.

A graduate of the Yale University course in hospital administration, Mr. Sable took his administrative residency at Beth Israel Hospital in Boston.

MANUEL J. SEGALL, former administrative assistant at the Jewish Hospital, Brooklyn, N. Y., has been appointed administrative assistant at Mount Zion Hospital, San Francisco.

Mr. Segall received a master's degree in hospital administration from Northwestern University and served his administrative residency at the Grant Hospital in Chicago. He is a personal member of the American Hospital Association and a nominee of the American College of Hospital Administrators.

RICHARD L. JOHNSON has been appointed administrative assistant of University of Chicago Clinics and also will be assistant director of the hospital administration program, a faculty appointment in the School of Business at the University of Chicago.

Mr. Johnson served his administrative residency at Norwegian-American Hospital in Chicago, after completing the hospital administration course at the University of Chicago.

During the last year, Mr. Johnson has been with the headquarters staff of the American Hospital Association. He has been preparing an Association manual, to be published this summer, on admitting policies and procedures.

Mr. Johnson's twin brother, Everett, completed the hospital administration course at the University of Chicago in 1950 and served his administrative residency at Methodist Hospital in Gary, Ind.

ALBERT S. DEANE JR. succeeds JAMES H. COOKMAN who resigned as administrator of the Framingham (Mass.) Union Hospital. The appointment is effective Aug. 1.

WILLIAM HERIN WAITE has been appointed administrative assistant at Pennsylvania Hospital, Philadelphia.

Mr. Waite is a graduate of Brown University and received a master's degree in hospital administration from the University of Minnesota. He served his administrative residency at Rhode Island Hospital, Providence, and Syracuse (N.Y.) Memorial Hospital.

GEORGE R. WREN has been appointed superintendent of Methodist Hospital, Gary, Ind., succeeding J. MILO ANDERSON, who now is administrator of the Ohio State University Medical Center, Columbus.

MR. WREN

Mr. Wren, a graduate of the hospital administration course at Chicago University, served his administrative residency at Methodist Hospital, Indianapolis.

L. W. HAMMETT, purchasing director of Michael Reese Hospital in Chicago, has resigned to become vice president of a Baltimore drug company.

Mr. Hammett, who entered the hospital field from private business about eight years ago, was formerly purchasing director at Sinai Hospital of Baltimore, Md.

HOWARD E. BISHOP, administrator of Robert Packer Hospital in Sayre, Pa., has retired after 39 years at that hospital.

MR. BISHOP

A life member of the American Hospital Association, Mr. Bishop has been actively interested in that organization, having attended the last 38 annual meetings. He also is a member of the Hospital Association of Pennsylvania and has served as its executive secretary.

Mr. Bishop will continue to serve on the board of trustees of Robert Packer Hospital.

ROY J. WHEELER, formerly with the Hillcrest Hospital, Tulsa, has been appointed superintendent of the Okmulgee (Okla.) City Hospital, succeeding MARY PRICE WILLIAMS who has retired.

JOSEPH W. HINSLEY has resigned as assistant director of Touro Infirmary, New Orleans, to accept the appointment of administrator of the new Lake Charles (La.) Memorial Hospital now under construction.

Mr. Hinsley is a past president of the New Orleans Hospital Council and a personal member of the American Hospital Association.

CHARLES W. FLYNN has resigned as administrator of the District Two Community Hospital, Durant, Miss., to become executive secretary of the Mississippi State Hospital Association.

MR. FLYNN

After graduation from Mississippi State College, Mr. Flynn taught hotel management at the college for one year and then entered the hospital field. He served his residency at the North Mississippi Community Hospital, Tupelo, Miss. He is a personal member of the American Hospital Association.

Mr. Flynn has been succeeded at the District Two Community Hospital by LILLIAN NORRIS, who formerly was surgical nurse supervisor there.

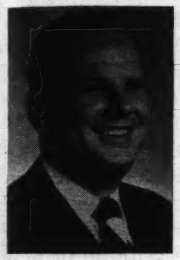
LAWRENCE R. PAYNE, executive director of the East Texas Hospital Foundation, will be administrator of the Medical Center Hospital in Tyler, Texas. The hospital, scheduled to open in August, has a bed capacity of 166 of which about 26 are bassinets.

The Veterans Administration has announced the appointment of DR. HOUGHTON W. BAXLEY as manager of the Huntington (W. Va.) Veterans Administration Hospital. He replaces SAMUEL R. GOODWIN, who has retired.

Dr. Baxley was formerly manager of the Veterans hospital in Fort Benjamin Harrison, Ind. DR. CLIFTON H. SMITH, who has been manager of a Veterans hospital in Atlanta, will succeed Dr. Baxley.

After the Fort Benjamin hospital closes in 1952, Dr. Smith will become manager of a new Veterans hospital scheduled to open then in Indianapolis.

HARRY N. DORSEY, a June graduate of the University of Chicago hospital administration program, has been appointed administrator of the Western Psychiatric Institute and Clinic of the University of Pittsburgh.



MR. DORSEY

While serving in the Army, Mr. Dorsey was an executive officer at the Station Hospital at Shaw Field, Sumter, S. C., and held various other hospital administrative offices.

Mr. Dorsey was administrative assistant at the Johns Hopkins Hospital in Baltimore for three years. He is a personal member of the American Hospital Association.

MARY M. THOMPSON, director of the infirmary and associate professor of nursing at the New Jersey College for Women, has retired after 31 years at the infirmary.

Miss Thompson is a graduate of the St. Luke's Hospital Nursing School, New York City.

Correction

SISTER MARY PAUL, administrator of Seton Institute, Baltimore, has been appointed administrator of St. Leo's Hospital, Greensboro, N.C., instead of St. Luke's Hospital, as reported in HOSPITALS for April.

Deaths

EDITH B. IRWIN, who, before her retirement March 1, had been administrator for 25 years of the Westmoreland Hospital, Greensburg, Pa., died June 3.

Miss Irwin was graduated from the University of Pennsylvania school of nursing and served in the Army Nurse Corps in World War I. She had been directress of nurses, Woman's College, Philadelphia, and superintendent of the Columbia Hospital, Wilkinsburg, Pa.

A former second vice president of the American Hospital Association, Miss Irwin was a fellow of the American College of Hospital Administrators and a member of the Hospital Association of Pensylvania and the Hospital Conference of Pittsburgh.

HOWARD S. LYON, treasurer of the New Jersey Hospital Association for the last two years, died of a heart attack in May.

Mr. Lyon had been president of the Somerset Hospital, Somerville, N. J., for some years. He was mayor of Somerville and a former president of the New Jersey Bankers Association.

ROBERT L. BACON, administrator of Hoag Memorial Hospital, Newport Beach, Calif., died suddenly May 19. He formerly was administrator of the Pomona (Calif.) Valley Community Hospital.

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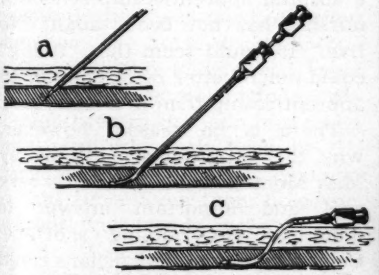

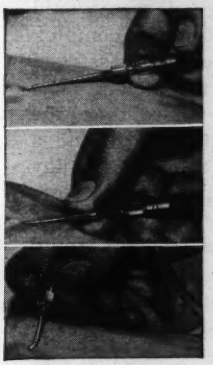

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A new plan for educating and training nursing technicians

IN HER BOOK, "The Education of Nursing Technicians,"* Miss Montag presents a new plan for nursing education and at the same time summarizes various aspects of nursing which at the moment are under critical scrutiny.

The 137 pages are divided into seven chapters, including an introductory and a summary chapter. The foreword is written by R. Louise McManus, Director of the Division of Nursing Education at Teacher's College, Columbia University.

The needs of society for nursing services and the factors which have distorted and developed the needs are well explained. A good statement is made to explain why today, when we have more nurses than we have ever had before, a shortage of nurses exists.

The discussion of the present status of schools for registered nurses reiterates the contentions expressed in the Brown Report and so often repeated by nurse educators that the hospital schools of nursing fail to educate the nurses for living as well as for making a living. It seems improper to have the student nurse pay completely for her education through service to the hospital when records show that a student going to college or to a university pays only 34.7 per cent of the costs for her nursing education.

To explain what a nursing technician is, the author indicates that nursing can be considered to be a continuum or as having a spectrum-like range. On one extreme are the simple functions based on common knowledge which most anyone is able to do or learn on the job. On the other and more broad extreme are the functions which are extremely complex, which require a high degree of skill and expertness acquired through long periods of training. The main volume of nursing lies somewhere between the two extremes, and these are described as being semi-professional or technical in nature. The aide can be taught on the job to do the simple functions. The professional nurse, graduated from a school of nursing conducted by an educational institution and holding a degree, would be responsible for the complex tasks. The rest would be assigned to the nursing technician, who would be a little more than the present-day practical nurse and a little less than the present-day registered nurse graduating from a three year hospital school.

The nursing technician would function to assist in the planning of nursing care for patients, to give general nursing care with supervision, and to assist in the evaluation of nursing care given. The name "nursing technician" has been chosen as being descriptive, for Webster defines technician as a "person skilled in technics or some practical art." Her education would be directed not only at teaching her these skills but also at developing in her "skill in the art of communication, knowledge of the economic system, understanding of people and social institutions, and an appreciation of the privileges and obligation of citizenship."

The schooling would be given in a community or junior college and would last two years. The curriculum is suggested and indicates that sociology, elementary economics, human growth and development, literature, history of the United States, introduction to government, and communication skills would make up 16 of the 65 credits.

Not just hospital facilities but those of public health agencies, clinics and home care programs would be used to give the 456 hours of clinical experience planned.

The study includes discussion of finance, administration, selection of students, faculty personnel needed and outline of recommended courses, and description of new courses.

Miss Montag has presented well her assumptions and has planned her program well for educating nursing technicians. There are statements regarding present-day nursing education, and hospitals' control of it, with which one could easily take exception. It is difficult, for example, to understand how in four semesters of schooling the nursing technician is going to be taught how to "live effectively" as well as learn basic simple nursing techniques, when the graduate of a hospital apprenticeship school of nursing has not been taught "to live." It would seem that "living" could much better be learned in an apprenticeship than in a classroom.

There is no reason, however, why this program as outlined by Miss Montag would not be a very real and important answer to much of our nursing shortage. Certainly nursing technicians could do what student nurses are now doing every day in many of our hospitals. Certainly they would seem to be a more adequate answer than the present practical nurse. If the program as outlined were adopted the changes resulting would be far reaching.—EVA H. ERICKSON, R.N., B.S., M.H.A., *administrator, Galesburg Cottage Hospital, Galesburg, Ill.*

*THE EDUCATION OF NURSING TECHNICIANS. Mildred L. Montag, Ed. D. New York, G. P. Putnam's Sons. 1951. 137 p. $2.50.

Historical documents

Two valuable documents have recently been added to the library's collection of rare books and are helpful in reconstructing

a picture of hospital life and problems in the last century.

The older of these, "Report of the Committee on a Free City Hospital (Boston)" was published in 1861. The committee first reports on the need for such an institution which would admit all patients, regardless of type of disease or economic position, and explains what influenced their selection of the site. The choice of architects was in open competition; the grand prize was to be $300, but plans submitted were so excellent that the prize was split: $200 for the best, and $100 for the runner-up. The winner, Gridley J. F. Bryant, in his letter of transmittal, described his pavilion-type plan. Some of his statements, such as, "A hospital is intended for the accommodation of patients and not for the attendants," and "It is a hospital and not a hotel," have current applications. Plans of the site and of the hospital are appended.

The second document is a July 1878 issue of *Harper's Monthly* in which a 19-page illustrated article on "Hospital Life in New York" appears. The style of writing, verbose and flowery, is far different from the factual presentation found in a present-day hospital survey. According to the report, hospitalization was much different then too. The horse-drawn ambulances and the telegraphed messages evoke amusement today, although present-day administrators may wishfully look back at the huge bequests to hospitals, common at that time. Even then, however, present day trends were in evidence: Laundries in hospitals, selective food service, and rehabilitation. The choice of hospitals included for review was representative rather than comprehensive. The three best depicted were New York Hospital for its magnificence, Bellevue for its extent, and St. Luke's for its homelike qualities.—H.T.Y.

Inquiries about books reviewed in the Literature department should be addressed to the American Hospital Association Library—Asa S. Bacon Memorial, 18 E. Division Street, Chicago 10. The department is edited by Helen V. Pruitt, librarian.

Films for administration

Gerhard Hartman, Ph.D., director of the course in hospital administration at the University of Iowa, has had the assistance of Jeanette H. Fessenden, administrative associate, in the compilation of a classified list of films, primarily selected for use in teaching hospital administration.*

The films have been grouped into 34 categories, *e.g.*, business management, chronic disease, dietary department, housekeeping, laundry, medical science, operating room, personnel management, public relations, and rehabilitation. Essential information about each film (date, length, color, sound, where it may be obtained) is included, with a very brief description of the content of the film.

Some of the films are especially adapted to in-service training. Most of these have been included in the list published in this section in HOSPITALS for October and November 1950. Other films have been reviewed and shown to the students as background, both general and specific, for a career in hospital administration. Users of films as teaching aids will want to add this bulletin to their collection of source material.

Infant formulas

MAKING BABY'S FORMULA (a slide film with recorded narration).

The Evaporated Milk Association has prepared a film and accompanying booklet to teach mothers how to properly make formulas. This film is suitable for use in classes which many hospitals conduct for new mothers. Included is a mimeographed copy of the recorded narration, which the instructor could use, either with or without the record itself. Because it is a slide film, there can be longer discussions of each procedure if desired. The technique described is that of terminal sterilization of both formula and bottles, similar to the procedure recommended for the infant formula room in the hospital. Simple equipment is used, such as could be obtained by any mother. The American Hospital Association's library has one copy of the slide film and record, which may be borrowed by member hospitals wishing preview of the film. If the hospital then wishes to make regular use of the film, it can arrange to do so by writing the Evaporated Milk Association, 307 N. Michigan Avenue, Chicago 1. Copies of the booklet, which is illustrated with pictures used in the film, are available to distribute to the mothers.

*Selected Films for Hospital Administration. State University of Iowa, Extension Bulletin Number 657, April 1, 1951. Iowa City, Iowa. 31 p.

Tuberculosis statistics

TUBERCULOSIS PATIENTS IN SANATORIA IN NEW JERSEY; A STATISTICAL ANALYSIS OF RECENT TRENDS. Emil Frankel, Director of Statistics and Research. Trenton, N.J. 1950. 17 pp.

Statistical data in 25 tables show the present situation in the hospitalization of tuberculosis patients, plus a comparison with data of previous years. With the help of these figures it is possible to trace the distribution picture in respect to age, sex, extent of pulmonary lesion on admission, length of stay, condition on discharge and percentage of discharges against medical advice. In spite of the gains made in tuberculosis casefinding and efforts at early detection, for the five year period, 1945-49, 58.9 per cent of the total number of patients admitted were diagnosed as far advanced on admission to a hospital.

One table indicates a constantly decreasing trend to leave a sanatorium without consent. For example, in 1944, 43 per cent of the males left against advice as contrasted with 26.2 per cent in 1949; in 1944, 38.8 per cent of the women left against advice and in 1949 the figure was reduced to 19.9 per cent. The total number of admissions in the entire state increased slowly from 14,117 in the period 1930-34, to 15,374 in the period 1945-49.

While these data are quite detailed for New Jersey, showing performance in each of the 14 sanatoria, and in the counties of the state, they are of interest to anyone studying the trend of the incidence of tuberculosis, and the problems of hospitalization of tuberculosis patients. The report is factual and does not interpret the statistical data.

NEWS

· · FEDERAL, ADMINISTRATIVE · ·

World Study of Hospitals

A resolution recommending a study on work being done by hospitals and other facilities for the promotion of health in member countries of the World Health Organization has been unanimously adopted by that assembly, which convened May 7-25 in Geneva, Switzerland. The resolution was submitted on behalf of the United States delegation by Dr. Malcolm T. MacEachern, director of professional relations for the American Hospital Association.

One of the functions of the World Health Organization, as stated in its constitution, is to study and report, in cooperation with other specialized agencies when necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security.

Because the hospital is becoming a more important factor in health, the United States delegation extended a belief that a study of hospital services could be effectively used as a means of reaching the over-all objectives of the World Health Organization.

The resolution adopted follows.

The Fourth World Health Assembly:

1. Recognizing that, among the many services essential for the care of health, hospitals through their facilities, trained personnel and organization, contribute effectively to world health;

2. Notes that it is difficult as well as undesirable to draw a definite line of demarcation between curative and preventive medicine; and

3. Recommends that, so soon as funds may become available for this purpose, the director general, in cooperation with appropriate agencies, prepare a study on the work being done in member countries to promote the health of their people through good hospitals and other facilities including domiciliary services, for the care of the sick in order to further the objectives of the World Health Organization.

Hill-Burton Projects

The latest monthly report of the Hospital Facilities Division, Public Health Service, discloses that as of April 30, 1951, a total of 1,535 Hill-Burton hospital construction projects had been approved. Of this number, 431 were completed and in operation, 900 were under construction, and the remaining 204 were in initially-approved status. Aggregate estimated cost of all 1,535 projects is $1,128,645,795, of which the federal share is $407,-154,974. They comprise an addition of 73,883 hospital beds and 234 health centers.

Hospitalization for Aged

At a press conference in Washington on June 25, Federal Security Administrator Oscar R. Ewing disclosed details of a plan to provide hospital care benefits to social security beneficiaries. Mr. Ewing said he will recommend such a plan to the President and he expects a bill to be introduced at this session of Congress.

The proposal, as outlined by Mr. Ewing, would provide hospitalization insurance up to 60 days a year for persons 65 and older and dependents of deceased persons insured under the Old Age and Survivors Insurance system.

The full cost of these hospitalization benefits, the administrator said, can be paid out of present social security payroll deductions, hence "these do not need to be increased and no general tax money is required."

About 5,000,000 people now 65 or older are receiving social security retirement benefits and more are eligible but are not receiving benefits because they are employed. All such persons could get the hospital coverage.

Under this plan, benefits would be confined to room and board on a semiprivate basis and not to medical or surgical charges or to x-rays and such specialized charges.

Details will be reported in HOSPITALS for August.

New Surgeon General

Maj. Gen. George E. Armstrong has been appointed surgeon general of the Army, succeeding Maj. Gen. Raymond W. Bliss who has retired after 40 years of service with the Army.

Gen. Armstrong is a graduate of Indiana University and had been deputy surgeon general of the Army since 1947. During World War II he was assistant surgeon of the China-Burma-India Theater and later surgeon of the China Theater.

Health Assignments

Public Health Service has announced that Anna Heisler, who retired from Public Health Service last December, will serve as acting director of public health nursing in the Alaskan Territorial Government, beginning August 15 with headquarters in Juneau. She takes the place of Dorothy Whitney, director, absent on educational leave.

Miss Heisler joined Public Health Service in 1935 and was the first public health nurse consultant assigned to a regional office following passage of the Social Security Act. A native of Missouri, her present home is in Bethesda, Md.

Another distant assignment is that of Mary Jean Yardley, who has been assigned to Thailand (Siam) to do public health nursing under sponsorship of Economic Cooperation Administration.

Commissions for Dietitians

United States Air Force is attempting to recruit more women for its medical branch. Qualified dietitians, heretofore ineligible for appointment in the Women's Medical Specialist Corps, may now apply for commissions, according to a recent announcement by Surgeon General Harry G. Armstrong.

Successful applicants must possess a bachelor's degree and either a hospital dietetic internship or three years of hospital experience including work in diet therapy, menu planning, supervision of food preparation and service and food financing and purchasing.

Warm Weather on Capitol Hill

Capital observers agree that the present 82nd Congress is bidding to set a new and dubious record for paucity of work accomplished. As far as health and hospital legislation is concerned, just about the only significant thing to show for the year's first half is a $95 million appropriation for continuance of the Hill-Burton program in 1952. This represents a $10 million increase over the sum available for the fiscal year ended June 30, 1951.

With the advent of warm weather in June, attendance of Senate and House members has fallen to a point where on many days it has been difficult to muster quorums, both in the main chambers and at committee meetings. One delay after another has postponed publication of the Senate reports on voluntary health insurance and administrative reform of hospital and medical services in Veterans Administration.

Spearheaded by the Citizens Committee on the Hoover Report, a drive was launched in June for establishment of a Department of Health but chances appear slim for this bill. There have been sporadic efforts also toward enactment of federal financial support of medical and nursing schools, local public health units and income tax deductions for premiums paid into voluntary hospital and medical care plans.

With Congress preoccupied in its investigation of Administration foreign policies and passage of appropriations and certain other "must" bills, all indications are that no new domestic programs of national significance—in the health field or any other—will be launched before termination of the first session of this Congress in late summer or early fall. It is in the second session, opening in January 1952, a national election year, that Congress may be expected to address itself more diligently to domestic legislation and thereby gain campaign material for the polls battles.

Progress on EMIC

Although the Senate subcomittee on health legislation, headed by Herbert H. Lehman (Dem., N. Y.), is virtually inactive, its professional staff is busily engaged in sifting communications on various issues and preparing drafts of bills. Emphasis is currently being placed on revival of the World War II Emergency Maternity and Infant Care plan (EMIC) for financial relief of servicemen's families in payment of hospital and doctors bills incidental to obstetrical and pediatric services. Early in June, staff members went to Chicago to confer on this subject with the American Medical Association. Later in the month, Dr. Dwight Murray and Dr. Walter B. Martin came to Washington to discuss EMIC and its proposed revival with Sen. Lehman. Dr. Murray is the new chairman of the AMA's board of trustees and Dr. Martin is a board member.

Proposed Health Department

The campaign led by the Citizens Committee for the Hoover Report for establishment of a Department of Health, placing all governmental hospital and medical services under one roof, was dealt a severe blow in mid-June. The Senate Expenditures Committee at that time made public a series of official comments on the proposal, all of them adverse.

The Bureau of the Budget objected on grounds that administration of veterans' and military hospitals is now being carefully coordinated and to divorce them from Veterans Administration and Department of Defense operation would be fraught with danger. Similarly it was pointed out that the Public Health Service is too closely aligned with other units of Federal Security Agency—notably Children's Bureau and Office of Vocational Rehabilitation—to make the removal of its marine hospitals feasible.

"The proposal runs counter to the historic policy of our government to treat its veterans as a class, deserving of special consideration," Veterans Administrator Carl R. Gray Jr. informed the Senate Expenditures Committee.

The Army and Navy likewise expressed opposition to the change, as did Federal Security Administrator Oscar R. Ewing, who still feels that any new Cabinet-status department should be devoted not to health and hospitals exclusively but jointly to health, education and social welfare.

Deductions for Health Plans

Members of Congress who are seeking a middle-of-the-road type of national health program and who are skeptical of a Department of Health, Education and Security are partial, in many instances, to the voluntary prepayment approach which encourages enrollment by offering a form of income tax relief. Latest member to sponsor a bill is Rep. L. Gary Clemente (D., N. Y.), who has introduced HR 4405 for consideration by the House Ways and Means Committee.

Its purpose, "to allow medical and dental expenses as deductions from gross income for income tax purposes," the bill's chief provision, is as follows:

"Expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse or a dependent (shall be deductible). The term 'medical care,' as used in this subsection, shall include amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purposes of affecting any structure or function of the body, including amounts paid for accident or health insurance."

Transfer of Health Committee

The Health Resources Advisory Committee of the National Security Resources Board has been transferred to the Office of Defense Mobilization, Charles E. Wilson, ODM director, has announced.

One of the major activities of the committee since its formation has been the coordination of both federal and non-federal health programs to insure maximum utilization of health personnel, particularly physicians, dentists and nurses.

The committee has been responsible for advising W. Stuart Symington, former NSRB chairman, and making policy recommendations on mobilization, allocation and utilization of personnel necessary for wartime health services, and provision of health equipment and supplies.

• • NATIONAL EMERGENCY • •

Report Past and Future Allocations

In some quarters of the capital, problems affecting the nation's hospitals are being attacked with an energy that is not manifest in the halls of Congress. As a claimant agency in the government's mobilization machinery, Public Health Service has made good progress in protecting interests of hospitals requiring construction materials. The Federal Civil Defense Administration, while sorely handicapped by lack of funds, is making definite headway in this field. And on the military side, procurement of medical officers and more efficient utilization of manpower and hospital resources supply grounds for optimism.

A few weeks ago, the Federal Security Agency (via Public Health Service) and Defense Production Administration jointly announced allocations of steel, copper and aluminum for hospital construction and expansion in the months of July, August and September. The awards were regarded as eminently fair and commensurate with the status of hospitals as a vital cog in the country's defense establishment.

For the third quarter of 1951, under provisions of the so-called Controlled Materials Plan which takes effect July 1, 75,000 tons of structural steel is earmarked for hospitals and health facilities; 950,000 pounds of stainless steel; 4,600,000 pounds of copper and copper base alloy, and 550,000 pounds of aluminum. At the same time, the following allocations were made for school, college and library construction: Structural steel, 100,000 tons; stainless steel, 80,000 pounds; copper and copper base alloy, 600,000 pounds, and aluminum, zero.

Dr. Leonard A. Scheele, surgeon general of the Public Health Service, stated: "The allocation of definite amounts of these basic materials for use in the construction of hospitals and other health facilities will be of great service to hospital authorities and contractors. It will enable them to plan with the definite assurance that the materials they require will be available.

"Not all of our hospitals will get all of the materials they want. Essential as new hospital construction is, however, we must recognize that our needs in this area must be thought of in relationship to the needs of our armed forces and our expanding defense economy. Intelligent planning of projects, the postponement of nonessential ones and the conservation of critical materials, such as the use of reinforced concrete instead of structural steel frames, whenever feasible, should make it possible for this allocation to provide for essential needs in the immediate future."

Scrap Shortage

A request for the salvaging of iron and steel scrap has been made by the Department of Commerce, National Production Authority. An estimated 32,500,000 gross tons of scrap is needed by steel mills in 1951 to meet production needs.

The department suggests hospitals organize a scrap program to get the maximum amount of scrap iron and steel into processing as quickly as possible by: (1) Searching out all dormant scrap; (2) consideration of wrecking or dismantling projects that will produce scrap, and (3) getting scrap into normal channels as early as possible.

Veterans Recruit Female Aides

Managers of veterans hospitals have been given the green light by Dr. Joel T. Boone, chief medical director, to add more female attendants to their staffs, particularly on the psychiatric services. His action was prompted by the relative scarcity of male attendants and a recommendation by Veterans Administration personnel officials that women be hired in larger numbers.

Also an influencing factor was a recent report from the chief nurse of a neuropsychiatric hospital, quoted below in part:

"For the past six months it has become increasingly difficult to recruit male aides who seem to be the kind we want to care for mentally ill patients. It was felt that rather than accept males of low caliber, it would be better to recruit females with acceptable qualities.

"There was much discussion concerning the advisability of this step. Everyone agreed that female aides doing bedside nursing was most acceptable but the male aides and some doctors and nurses were most reluctant to have the females assigned to the neuropsychiatric unit. In the past six months, we have hired female aides and now approximately 30 per cent of our aide personnel is female.

"They are assigned to work on any neuropsychiatric unit. They seem to have made an excellent work adjustment and are now accepted by all members of the treatment team."

PREPAID CARE

Self-Discipline by Hospitals

After a frank discussion of fiscal relations with their Blue Cross plan, members of the Maritime Hospital Association in Canada have set up a program of self-discipline with respect to exorbitant charges and other abuses, which were reported as currently burdening the plan (Maritime Hospital Service Association) with avoidable expenditures.

This action was taken at the close of the Maritime Hospital Association's June 5-7 meeting in St. Andrews, N.B. Presiding at the meeting was A. D. McInnis of Antigonish, N.S., the 1950-51 president of the association.

By resolution the association invited its Blue Cross plan to report "exorbitant charges and other abuses." If no remedial action is forthcoming within three months,

the plan is urged to cancel the contract of any member hospital. Concurrently the association authorized a special committee of three appointed representatives to call on the accused hospital and attempt to bring about the remedial action necessary to avoid cancellation.

In another resolution, also aimed at the crucial problem of Blue Cross-hospital financial relations, the association requested that its three-member conciliatory committee undertake a study of the cost of anesthetic materials, dressings and other services and determine proper charges to Blue Cross.

Facts brought out during the meeting showed that the Blue Cross plan had a net loss of over $100,000 during 1950. Beginning in January 1951, hospital bills were pro-rated so that hospitals received less than full payment for patient care. Blue Cross representatives stressed the fact that if abuses were cut out of hospital bills, the plan would not have to pro-rate and would be financially solvent.

A display card was used to show how bills could be reduced by cutting down the length of stay in the hospital, laboratory fees, anesthetic charges, dressings, x-ray and drugs. The 1950 deficit would have been wiped out, said plan executives, if savings could have been effected on items such as these.

Virginia Plan Dissolves

The Virginia Peninsula Hospital Service Association, Newport News, a Blue Cross plan, has been dissolved and the territory served by it has been reassigned to the Virginia Hospital Service Association, Richmond.

Since the resignation of P. Lynwood Taylor as manager of the Newport News plan, that plan has been under the administration of the Richmond plan officials. Members of the Newport News plan will be invited to subscribe to the Richmond plan.

Membership Gains

With the addition of 606,071 new members during the first quarter of 1951, enrollment in the 91 Blue Cross plans reached 40,838,768 on March 31.

Based on the 1950 official United States census, the 85 plans serving 47 states and the District of Columbia have enrolled 25.23 per cent of the combined population served by the plans. Five Blue Cross plans serving eight Canadian provinces have enrolled 26.91 per cent of their combined population. Puerto Rico Blue Cross has enrolled 3.75 per cent of the island's population and 1.57 per cent of the Alaska population has Blue Cross.

Associated Hospital Service of New York made the highest gain—138,332 new members and Michigan Hospital Service was second with a gain of 97,851.

Hospital Service Corporation of Rhode Island still leads all plans in percentage of state population enrolled with 73.49 per cent of the state covered.

Inter-Plan Bank Growth

The Inter-Plan Bank of the Blue Cross Commission celebrated its second anniversary on May 1. Comparative figures for the first month of operations in May 1949 and the 24th month in April 1951 reveal how the bank has grown during the two years.

In May 1949 the bank handled 1,090 cases, involving 5,166 days of care. Payments to hospitals during that first month totaled $59,712.05.

In May 1951 the bank recorded its largest monthly volume of business. A total of 11,922 cases were handled, involving 86,176.4 days of care. Payments to hospitals amounted to $1,109,553.17.

At the present time 77 Blue Cross plans, including the five Canadian plans and the Puerto Rico plan, are participating in the bank. This total includes the following plans, which joined July 1: New Hampshire-Vermont Hospitalization, Concord, N. H.; Associated Hospital Service, Inc., Youngstown, Ohio, and Marion County Hospital Service, Inc., Fairmont, W. Va.

1950 report: The bank handled 101,246 cases during 1950 involving more than 750,000 days of care. Payments to hospitals totaled $9,034,013.26.

Average length of stay increased slightly during 1950 to 7.41 days, as contrasted to 7.21 days in 1949. Cost per case rose more markedly, to $89.23, against the 1949 figure of $83.79.

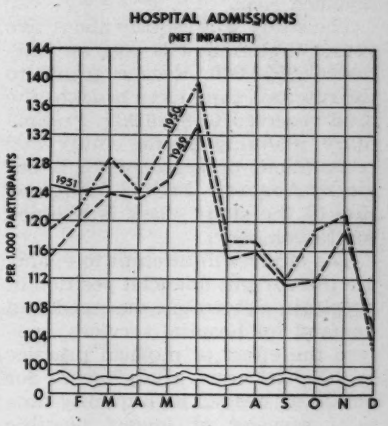
Grant to Insurance Plan

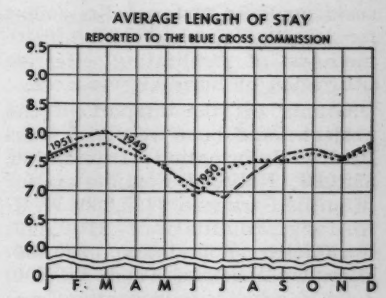
The Commonwealth Fund has made a grant of $150,000 and the Rockefeller Foundation a grant of $155,000 to the Health Insurance Plan of Greater New York for the study of family experience in medical care based upon statistical data assembled by the organization.

The analysis will cover four years of experience on the part of a substantial sample of the total plan membership. The director of the study will be Neva R. Deardorff, Ph.D., director of research and statistics for the New York plan.

Statistical Manager

Ruth E. Gardiner has succeeded Lynn A. Doctor as manager of the actuarial and statistical division of the Blue Cross Commission in Chicago.





ADMISSION-STAY

Hospital admission rates during the first three months of 1951 have remained almost constant. The rate was 125 per 1,000 Blue Cross members in January, 124 in February, and 125 in March. The March 1950 rate was 130 per 1,000 participants.

The average length of stay of hospitalized Blue Cross patients increased from 7.56 days in January to 7.83 days in February. The average stay for February 1950 was 7.81 days.

Inpatient days of care provided by Blue Cross plans increased approximately 20 per cent during February over the previous month. The increase, however, was not as great as that for the same period in the last two years. During February 1951 the plans provided 961 inpatient days of care. This was four days of care less than was provided during February 1950.

Hospital Costs Study to Begin Soon

Plans for the Association's study of the financing of hospital care moved a long step forward last month with the announcement that sufficient funds for the study now are assured. It is expected that the selection of a chairman and a director for the study will be announced soon.

The study will require about two years' time and will cost an estimated $500,000. Recent grants to the research fund have brought the total received to $446,000. Preliminary planning of the study and recruitment of personnel will begin by August 1. Formal inauguration of the study itself is planned for November 1.

The study will attempt to evaluate the current financial position of hospitals, determine the need and demand for hospital services, analyze the effect of medical practice on hospital costs, study means for obtaining needed high quality hospital services at lowest possible costs, evaluate systems of payment for hospital care and investigate methods of facilitating effective utilization of hospital resources.

Grants for the support of the project have been received from Health Information Foundation, $55,000; National Foundation for Infantile Paralysis, $225,000; W. K. Kellogg Foundation, $100,000; Rockefeller Foundation, $50,000; Milbank Memorial Fund, $10,000; John Hancock Life Insurance Company, $5,000, and private donations, $1,000.

The National Foundation for Infantile Paralysis has announced it will underwrite the balance of the $500,000 budget, if necessary, to make possible the immediate inauguration of the study.

The Association's committee on national study of the financing of hospital care includes Dr. Charles F. Wilinsky, president of the American Hospital Association; John N. Hatfield, administrator of Pennsylvania Hospital, Philadelphia; Dr. Morris Fishbein, former editor of the *Journal of the American Medical Association,* Chicago; Joseph G. Norby, administrator of Columbia Hospital, Milwaukee; and George Bugbee, executive director of the American Hospital Association.

Matching Internships

The National Interassociation Committee on Internships last month reported on the results of its experiment with a new system of matching internships and recommended that the plan be adopted as the official method of intern appointment for next year.

This plan (see HOSPITALS for May, page 68) would set up a system whereby medical school seniors would rank, by order of preference, the hospitals in which they desire internships, and the hospitals in turn would rate the students who apply. By a mechanical method, then, the selections of students and hospitals would be matched, the theory being that in this way both students and hospitals would be more likely to be satisfied with internship appointments.

The committee was established on a temporary basis last December and conducted a "trial run" with the year's intern appointments.

Before the new system can go into effect it requires approval of the interested organizations—the American Hospital Association, the American Medical Association and the Association of American Medical Colleges.

A permanent National Interassociation Committee on Internships would be established, with power to act on procedural matters relative to internship appointment. The committee would be responsible to the constituent bodies of the three associations and would have 11 voting members.

Under the matching plan, the student would do the following:

1. He applies to the hospital in the usual way, according to the hospital's regulations.

2. On a specified date, he prepares a confidential ranking of the hospitals to which he has applied. This is mailed to a central office.

3. He receives from the central office a confirmation list, which he checks for accuracy and revises if he wishes.

4. Later he accepts appointment to the hospital with which he has been matched according to his preference and the evaluation that the hospital has made of him. He and the hospital have previously agreed to abide by this decision.

The hospital would do the following:

1. It corresponds with and interviews students interested in applying for internship.

2. After the application time has closed, the hospital receives from the central office a list of students who have applied to that hospital. The hospital then indicates its evaluation of each student by rating him 1, 2, 3, 4 or 5, and returns the confidential list to the central office. (Rating No. 1 means most desirable; 2 means desirable; 3 means acceptable; 4 means acceptable only if all other applicants had not filled the quota; 5 means not acceptable.)

3. Later the hospital is told which students have been matched to its internships, and it has previously agreed to abide by the decision.

To implement this plan, a fee of $2.50 would be charged each student, matched by $2.50 by each hospital for each internship filled through the plan. A directory of approved participating hospitals would be prepared and distributed to the students. This directory would show the types of internships each hospital offers.

Administrative responsibility for the operations would be carried out by the Association of American Medical Colleges under regulations established by the National Interassociation Committee on Internships.

The plan, if adopted, would be followed for the appointment of students who will start their internships in July 1952.

Allied Groups in St. Louis

Annual meetings of three groups will be held in St. Louis during the week of the American Hospital Association's fifty-third convention. Program outlines for these organizations call for at least one joint meeting with the Association in addition to sessions of more particular interest to their own members.

The College: Indications point to a record number of admissions and advancements at the 17th annual

convocation of the American College of Hospital Administrators, September 16. More than 200 new nominees will be received into the college, approximately 150 advanced to membership and a substantial number to fellowship.

On Monday will be the annual Bachmeyer Address, commemorating Dr. Arthur C. Bachmeyer, director of University of Chicago Clinics. The address, established two years ago, is in the nature of a tribute to Dr. Bachmeyer by his former students.

Headquarters for the college will be in the Jefferson Hotel. The college also will have an educational exhibit in Kiel Municipal Auditorium.

Nurse anesthetists: Immediately preceding the annual meeting of the American Association of Nurse Anesthetists in St. Louis will be the assembly of directors of schools of anesthesia, which this year has been planned around the general topic of the organization's new accreditation program.

One of the convention sessions and much of the time set aside for business meetings also will be used for discussion of accreditation and progress in its establishment.

MISS CAMERON

Recipient of the annual award of appreciation will be Mae B. Cameron, director of the Ravenswood Hospital school of anesthesia in Chicago. Miss Cameron was elected vice president of the association at its first annual meeting in 1933 and was the first chairman of the anesthetists section of the Tri-State Hospital Assembly.

Headquarters for the anesthetists will be the Lenox Hotel.

Medical record librarians: The American Association of Medical Record Librarians also is sponsoring, prior to its convention, a workshop for instructors and directors of schools. It will be at the Sheraton Hotel, convention headquarters, September 13-15.

Hotel reservations for all these meetings, as well as the American Hospital Association's convention, must be made through the Hotels Convention Reservation Bureau, Room 306, 911 Locust Street, St. Louis 1.

Diversified Exhibits

High among reasons why the American Hospital Association's annual convention has, year by year, attracted more and more registrants is the Hospital Merchandise Mart, the vast display of commercial and education exhibits. At no other time and no other place during the year can so many representatives of hospitals and hospital supply and manufacturing companies get together to compare their needs and products.

At the 53rd convention there will be the largest display of exhibits ever sponsored by the Association in St. Louis. Many of the more than 300 exhibiting firms will be in booths on the arena floor, exhibit space heretofore not used by the Association when it has met in St. Louis' Kiel Municipal Auditorium. The majority of booths will be on the building's lower level.

Another significant development in this year's exhibit plans is the wide range of products which will be on view. It will be the most diversified display of nationally advertised products and services in the Association's history. More than 30 firms have secured exhibit space for the first time at an Association convention.

Educational exhibits by more than 25 organizations will be on view in the arena. The Association booth, in the lobby of the opera house, will be a handy place to secure information and meet friends.

A single exhibit is being planned this year by the federal agencies operating hospitals — the Army, Navy, Air Force, Public Health Service, Veterans Administration and Indian Service—and the Bureau of the Budget. The division of Hospital Facilities of the Public Health Service, as in the past, will have a separate exhibit.

· · EDUCATION · ·

Administrative Residencies for 1951

Students of hospital administration courses at 12 universities and Duke Hospital received their residency appointments last month. The residency, a requirement for a master's degree in hospital administration, is usually one year of administrative training in a hospital.

About 30 students were graduated from a 33-week hospital administration course at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

The University of Pittsburgh is releasing its first class of residents this year, and the State University of Iowa last fall completely revised its course to include a two-year residency. Steps are now being taken at other universities to set up courses in hospital administration.

Directors of the 13 university programs in hospital administration are: Richard J. Stull, University of California, Berkeley; Dr. Arthur C. Bachmeyer, University of Chicago; Dr. John E. Gorrell, Columbia University, New York; F. Ross Porter, Duke Hospital, Durham, N. C.; Gerhard Hartman, State University of Iowa, Iowa City; Dr. Ernest L. Stebbins, Johns Hopkins University, Baltimore; James A. Hamilton, University of Minnesota, Minneapolis; Dr. Malcolm T. MacEachern, Northwestern University, Chicago; Dr. Glidden L. Brooks, University of Pittsburgh; Rev. John J. Flanagan, S. J., St. Louis University; Dr. Harvey Agnew, University of Toronto; Dr. F. R. Bradley, Washington University, St. Louis; George S. Buis, Yale University, New Haven, Conn.

Students, preceptors and hospitals are:

UNIVERSITY OF CALIFORNIA

BATES, LEROY, M.D., to Dr. Carroll E. Palmer, chief, Field Studies Branch, Division of Tuberculosis and Chronic Diseases, U. S. Public Health Service, Washington (master of public health degree).

COCKS, LT. COL. CHARLES E. JR., M.D., to Dr. Charles E. Smith, dean, School of Public Health, and R. J. Stull, director of course in hospital administration, University of California, for further study (master of public health degree).

FABER, DONALD A., to George U. Wood, executive vice president, Peralta Hospital, Oakland, Calif. (master of public health degree).

HAYES, ROBERT W., to Dr. Walter Rapaport, superintendent, Agnew

MEMBERS of the 1951 hospital administration class at the University of California are: (seated, left) Keith O. Taylor (associate director), Frederick G. Welsh, Robert W. Hayes, Lt. Col. Charles E. Cocks Jr., (standing, left) Alfred F. Maffly (lecturer), Donald A. Faber, Thomas E. Tonkin, John Y. James, James W. McFarlane, Will Henderson, LeRoy Bates, M.D.

(Calif.) State Hospital (master of public health degree).

HENDERSON, WILL, to William B. Hall, administrator, University of California Hospital, San Francisco (master of public health degree).

JAMES, JOHN Y., appointment pending.

MCFARLANE, JAMES W., to John W. Doubenmier, superintendent, Kern General Hospital, Bakersfield, Calif. (master of public health degree).

TONKIN, THOMAS E., appointment pending.

WELSH, FREDERICK G., to Max E. Gerfen, administrator, Sequoia District Hospital, Redwood City, Calif. (master of public health degree).

UNIVERSITY OF CHICAGO

ALLEN, WALTER PIERCE, to Dr. Ralph Coon, superintendent of Wisconsin General Hospital, Madison, Wis.

DANIELS, WILLIAM JAMES, to Ritz E. Heerman, superintendent of The California Hospital, Los Angeles.

HARDY, ROBERT CHARLES, to Arthur L. Bailey, administrator of Jefferson Hillman Hospital, University of Alabama, Birmingham, Ala.

IMHOFF, JOHN CLAWSON, to Stanley A. Ferguson, superintendent of Cleveland (Ohio) City Hospital.

JOHNSON, RODGER CARL, to Donald W. Cordes, administrator of Iowa Methodist Hospital, Des Moines, Iowa.

MOOTZ, BRADY LEE, to R. W. Bachmeyer, director of Aultman Hospital, Canton, Ohio.

RIDLEY, ELTON TAFT, to J. B. H. Martin, administrator of Indiana University Medical Center, Indianapolis.

ROBERTS, LESTER, to Frank J. Walter, administrator of Good Samaritan Hospital, Portland, Ore.

TAYLOR, JAMES MURRAY, to Hubert W. Hughes, administrator of General Rose Memorial Hospital, Denver.

LORIMER, BERNARD EUGENE, will return as administrator of Midland (Mich.) Hospital from which he has been on leave of absence while attending the course.

DORSEY, HARRY NORBERT, to the University of Pittsburgh, Western Psychiatric Institution and Clinic as administrator.

COLUMBIA UNIVERSITY

BARRENA, CARLOS, M.D., to Dr. Edward Kirsch, executive director of Lebanon Hospital, New York City.

BRANDT, MRS. PATRICIA M., to Miriam Curtis, director of Syracuse (N.Y.) Memorial Hospital.

NORTHWESTERN UNIVERSITY group, photographed during a field trip, are (front row, left) Richard Shedlovsky; Jurral Rhee; Edith May Beyer; Helen Chase; Harry Higgins, 1951 graduate; Lucille Fernleaf; Steven Pindiak; Robert Haskins; Carney Wright, part-time student; (second row, left) Yeshwant Nilajgi; Ellis Lindhorst; Ralph Hutchins; George Walls; William Gaston, withdrawn from the school; (third row, left) Coleman Foote; W. Ming Foo; William Rundle; Paul Elbow; William Howes, part-time student; Edgar Mansfield; Paul Keiser; H. A. Smith, representative of a pharmaceutical supply house; William Kramer; (fourth row, left) Oscar Luther; James Heidenreich; Mary Sim, part-time student; Doyle Taylor; Robert Denholm; Dr. Charles Letourneau, 1951 graduate; Charles Showalter; George Fleigh; Elbert Sledge; Herbert Abramson; Otis Wheeler; Paul Sodt; Thomas Askew; James Evans, part-time student, and Harold Peterson.

BULL, MAURICE, to Dr. A. P. Merrill, superintendent of St. Barnabas Hospital for Chronic Diseases, New York City.

BYARS, WARNER, to Dr. E. Dwight Barnett, director of Harper Hospital, Detroit.

CALVO, TOMAS, M.D., to Dr. James P. Dixon, director of Bureau of Health and Hospitals, Denver.

CARSON, LEON, to Howard E. Bishop, administrator of Robert Packer Hospital, Sayre, Pa.

DRUMM, RUSSELL M., to William J. Donnelly, administrator of Greenwich (Conn.) Hospital.

FLORES, EFRAIN, to Dr. Nathan Smith, medical superintendent of Morrisania City Hospital, New York City.

GARCIA, DAVID, M.D., to Dr. Vidal Tan, president, University of the Philippines, University Health Service, Diliman, Quezon City.

GOOBY, EDWARD, to Dr. Kenneth B. Babcock, director of Grace Hospital, Detroit .

HARTFORD, LYLE, to Dr. G. A. W. Currie, administrator of University of Colorado Department of Medicine, Denver.

KEENE, JOHN, to Frank P. Sauer, director of Muhlenberg Hospital, Plainfield, N. J.

KOACH, HAROLD, to David A. Endres, administrator of Youngstown (Ohio) Hospital.

LARKIN, THOMAS, to E. Atwood Jacobs, administrator of Reading (Pa.) Hospital.

COLUMBIA University's 1951 residents are (bottom row, left) Richard Ward; Lyle Hartford; Patricia Brandt; Dr. David Garcia; Michael Mertel; Charles Auslander; Dr. John Gorrell, course director; Joseph Terenzio; Dr. Carlos Barrena; Dr. Tomas Calvo; Anne Burfeindt; (second row, left) Leon Carson; Maurice Bull; Arcadio Torres; Efrain Flores Gallardo; Dr. Carlos Zamarripa; Dr. Martin Guzman; Edward Gooby; Russell Drumm; Nicholas Verrastro; Frank Monkus; (top row, from left) William P. Ryan Jr.; John Keene; Harold Koach; Warner Byars; William Worcester; Thomas Larkin; Joseph Owen, and John J. McDonald.

MCDONALD, JOHN, to Dr. E. Dwight Barnett, director of Harper Hospital, Detroit.

MONKUS, FRANK, to Dr. Robin C. Buerki, vice president in charge of medical affairs of the University of Pennsylvania, Philadelphia.

OWEN, JOSEPH K., to Charles P. Cardwell Jr., director, Medical College of Virginia, hospital division, Richmond.

RYAN, WILLIAM P. JR., to Dr. Wilmar M. Allen, director of Hartford (Conn.) Hospital.

SOYKE, JOHN, to E. L. Taylor, director, Graduate Hospital, University of Pennsylvania, Philadelphia.

TERENZIO, JOSEPH V., to Columbia University, New York City.

TORRES, ARCADIO, to Dr. J. Serra-Chavarry, Veterans Administration Center, San Patricio Hospital, San Juan, P.R.

VERRASTRO, NICHOLAS, to Charles V. Wynne, director of Waterbury (Conn.) Hospital.

WARD, RICHARD, to John S. Parke, executive vice president of the Presbyterian Hospital in the City of New York.

WORCESTER, WILLIAM JR., to Dr. Henry N. Pratt, director, Society of the New York Hospital, New York City.

GRADUATES OF the hospital administration course at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas, are: (first row, left) Lt. (j. g.) R. Bohannan; Maj. H. S. Andersen; Lt. Col. R. E. Paige; Col. J. W. Howard; Lt. Col. H. M. Abramoska; Maj. Gen. J. I. Martin, commandant of the school; Lt. Col. J. T. Richards, course director; Maj. F. E. Judd; Capt. V. L. Richardson; Lt. Col. G. E. Murphy; Capt. J. R. McLeland; (second row, left) Maj. C. W. Nicolary; Lt. Col. R. O. Pennepacker; Capt. J. D. Medwed; Capt. E. L. Thompson; Maj. H. A. Jones; Capt. E. C. Luscombe; Capt. J. S. Foley; Maj. R. R. Freeman; Lt. Col. E. Wilhoit; Lt. Col. R. Murray; (third row, left) Capt. H. C. Thomas; Capt. G. L. Grow; Maj. G. C. Irving; Maj. T. E. Baker; Lt. Col. R. H. Wingo; Lt. Col. J. F. Clark; Capt. H. J. Funston; Capt. E. E. Bates; Maj. F. O. DeSautels; Capt. R. L. Hughes; Capt. O. H. Sandman.

A REORGANIZED study program in hospital administration was introduced at the State University of Iowa last fall. Administration students pictured above are (front row, left) Paul S. Jarett; Theodore W. Frazier; Gerhard Hartman, Ph.D. (professor and director); Dennison L. Larson; Samuel F. Keefer; (back row, left) Charles A. McClain; Walter M. Balfour; Donald F. Rodawig; Donald J. Conroy; John P. Delaney, and Glenn H. Anderson.

ZAMARRIPA, CARLOS, M.D., to Dr. Nathan Smith, medical superintendent of Morrisania Hospital, New York City.

DUKE HOSPITAL

Seven students are now enrolled in the hospital administration class at Duke Hospital of Duke University. Although no degree is conferred for this work, a certificate in hospital administration is given after satisfactory completion of the program.

The men and their graduation dates are: Willie L. Simon, July 1, 1951; Charles H. Frenzel and John A. Lockhart, Jan. 1, 1952; Sherwood A. Smith, July 1, 1952; E. Allison Herron, E. Pridgen Barnes and Roy Bradley, Jan 1, 1953.

STATE UNIVERSITY OF IOWA

ANDERSON, GLENN H., to Clayton M. Bond, manager of the Sheboygan (Wis.) Clinic, and selected community hospitals.

BALFOUR, WALTER M., to Fred Graham, administrator of Colorado Springs Medical Center, and Sister Mary Lina, superintendent of St. Francis Hospital, Colorado Springs.

CONROY, DONALD J., to Robert G. Boyd, administrator of Morristown (N.J.) Memorial Hospital.

DELANEY, JOHN P., to Dr. E. Dwight Barnett, director of Harper Hospital, Detroit.

MINNESOTA hospital administration students beginning residencies this month are: (first row, left) Harold W. Peterson, Boyd A. Sanderson, Gaylord W. Anderson, M.D., (Mayo Clinic professor and director of the school of public health), James A. Hamilton (director of the hospital administration course), James W. Stephan (associate director), Eugene L. Staples, Robert J. Wilkins, (second row, left) James C. Talley, James D. Harvey, Donald E. Wood, Charles F. Harrienger, Vernon L. Harris, Donald E. Gilbert, Miguel A. Solar, M.D., Lawrence L. Wilson, Bright M. Dornblaser, David H. Hitt, James W. Knight, Elmer R. Salovich, Foster L. Riggs, Nick Rajacich, (third row, left) Joel H. Walker, John H. Daniels, Vance C. DeMong, Oren W. Govier, Herluf V. Olsen Jr., John W. Norton and Martin Saren.

FRAZIER, THEODORE W., to Charles E. Burbridge, superintendent of Freedmen's Hospital, Washington, D. C.

JARETT, PAUL S., to Ritz E. Heerman, superintendent of The California Hospital, Los Angeles.

KEEFER, SAMUEL F., to Gerhard Hartman, Ph.D., superintendent of State University of Iowa Hospitals.

LARSON, DENNISON L., to Gerhard Hartman, Ph.D., superintendent of State University of Iowa Hospitals, Iowa City.

MCCLAIN, CHARLES A., to Gerhard Hartman, Ph.D., superintendent of State University of Iowa Hospitals, Iowa City.

RODAWIG, DONALD E., to Alfred Bieber, administrator of Lutheran Hospital, Sioux City, Iowa.

JOHNS HOPKINS UNIVERSITY

COSTON, HAROLD P., to Robert S. Hoyt, director of Lutheran Hospital of Maryland, Baltimore.

MOYER, ALFRED D., to Parker J. McMillin, superintendent of Baltimore City Hospitals.

UNIVERSITY OF MINNESOTA

DANIELS, JOHN H., to Robert A. Kumpf, administrator of Lewistown (Pa.) Hospital.

DEMONG, VANCE C., to Dr. Thomas E. Broady, superintendent of Ancker Hospital, St. Paul, Minn.

DORNBLASER, BRIGHT M., to Lester E. Richwagen, superintendent of Mary Fletcher Hospital, Burlington, Vt.

GILBERT, DONALD E., to Lawrence J. Bradley, director of Genesee Hospital, Rochester, N. Y.

GOVIER, OREN W., to Leon N. Hickernell, director of Vancouver (B.C.) General Hospital.

HITT, DAVID H., Research Fellow, School of Public Health, University of Minnesota, Minneapolis.

HARVEY, JAMES D., to Bryce L. Twitty, administrator of Hillcrest Memorial Hospital, Tulsa.

HARRIS, VERNON L., to Russell C. Nye, administrator of Northwestern Hospital, Minneapolis.

HARRIENGER, CHARLES F., to Marie J. Doud, superintendent of Highland Hospital, Rochester, N. Y.

KNIGHT, JAMES W., to James McNee, superintendent of St. Luke's Hospital, Duluth, Minn.

NORTON, JOHN W., to Oliver G. Pratt, director of Rhode Island Hospital, Providence.

OLSEN, HERLUF V. JR., to Paul J. Spencer, director of Lowell (Mass.) General Hospital.

PETERSON, HAROLD W., to Dr. Benjamin W. Mandelstam, director

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5 Qt. makes 5 GALLONS.....each $4.50 case of 4.....$16.20

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5 Qt. makes 5 GALLONS.....each $5.25 case of 4.....$18.90

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1 Qt. makes 1 GALLON .....each $1.25 case of 12.....$13.50
5 Qt. makes 5 GALLONS.....each $4.50 case of 4.....$16.20

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MEMBERS OF the first class in hospital administration at the University of Pittsburgh's new graduate school of public health are shown above. From left in the first row are Richard Springer; Charles Gratz; Dr. Manuel Barquin; William Kimes; Dr. Chrysostomos Theodoridis, a special student from Athens, Greece, and Thomas Fitzpatrick. In the second row are Paul Halenda, special student; Gordon Elliott; Dr. Glidden L. Brooks, professor of hospital administration; Walter J. McNerney, instructor in the hospital administration course, and James Mayer. Vaughn D. Kahle and Frank Larsen are at the back.

of Mount Sinai Hospital, Minneapolis.

RAJACICH, NICK, to Dr. Edwin L. Crosby, director of Johns Hopkins Hospital, Baltimore.

RIGGS, FOSTER L., to Merton E. Knisley, administrator of St. Luke's Hospital, Milwaukee.

RINDFLESH, KENNETH A., to James P. Dixon, medical director of Denver General Hospital.

SALOVICH, ELMER R., to Dr. Karl Klicka, director of St. Barnabas Hospital, Minneapolis.

SANDERSON, BOYD A., to Dr. Peter D. Ward, director of Charles T. Miller Hospital, St. Paul, Minn.

SAREN, MARTIN, to Dr. Edwin L. Harmon, director of Grasslands Hospital, Valhalla, N. Y.

SOLAR, MIGUEL A., M.D., to John MacRitchie, administrator of Hillsdale (Mich.) Community Health Center.

STAPLES, EUGENE L., to Ray M. Amberg, director of University of Minnesota Hospitals, Minneapolis.

TALLEY, JAMES C., to Arden E. Hardgrove, superintendent of Norton Memorial Infirmary, Louisville, Ky.

WALKER, JOEL H., to Miriam Curtis, director of Syracuse (N.Y.) Memorial Hospital.

WILKINS, ROBERT J., to Frank J. Walter, administrator of the Good Samaritan Hospital, Portland, Ore.

WILSON, LAWRENCE L., to Boone Powell, director of Baylor Hospital, Dallas, Texas.

WOOD, DONALD E., to Ray Swanson, director of the Swedish Hospital, Minneapolis.

ST. LOUIS University residents are (seated, from left) Sister M. Lawrence, R.S.M.; Sister M. Thomas, R.S.M.; Sister M. Albert, R.S.M., and Louise M. Lang. Standing (from left) are Victor E. Costanzo, associate director; Robert W. Holters; Ignatius Joseph Shyne; Thomas H. Whalen; John W. Foley; Eugene H. Barbera; Warren S. Hinton; Frederick J. Zuber; Moises Amieiro, and Rev. Frank Dirksen. Philip K. Schumacher is also in the class.

NORTHWESTERN UNIVERSITY

ABRAMSON, HERBERT, to Dr. Maxwell S. Frank, director of Beth Israel Hospital, New York City.

ASKEW, THOMAS L., to John W. Gill, business manager of Mercy Hospital-Street Memorial, Vicksburg, Miss.

BEYER, EDITH MAY, to Josie M. Roberts, administrator of Methodist Hospital, Houston.

CHASE, HELEN E., to Gerhard Hartman, Ph.D., superintendent of State University of Iowa Hospitals.

CHERKAS, MARSHALL, to Samuel Gertner, executive director of Mt. Sinai Hospital, Miami Beach, Fla.

DENHOLM, ROBERT L., to Dr. G. A. W. Currie, director of Colorado General Hospital, Denver.

ELBOW, PAUL X., to Crayton E. Mann, administrator of Welborn Memorial Baptist Hospital, Evansville, Ind.

FERNLEAF, LUCILLE I., to Leo M. Lyons, director of St. Luke's Hospital, Chicago.

FOO, WELLINGTON MING, to Dr. Kenneth Babcock, director of Grace Hospital, Detroit.

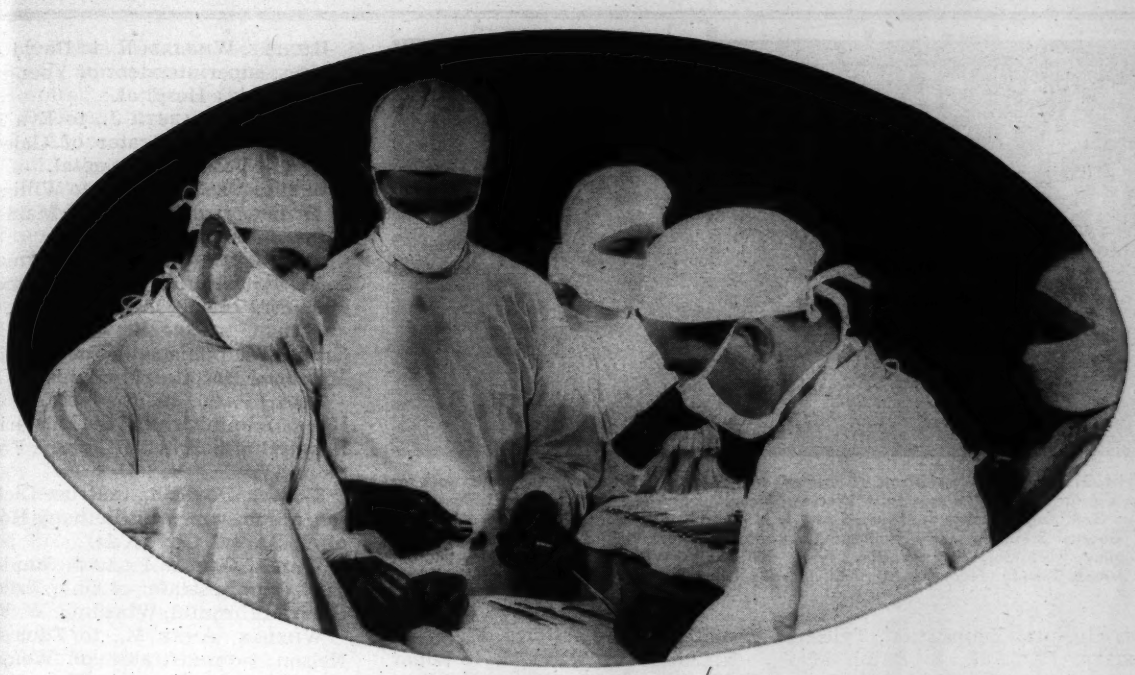
FOOTE, COLEMAN H., to Leo M. Lyons, director of St. Luke's Hospital, Chicago.

GILBERT, ORRIE L., to D. O. McClusky Jr., administrator of Druid City Hospital, Tuscaloosa, Ala.

HASKINS, ROBERT C., to Richard D. Vanderwarker, director of Passavant Memorial Hospital, Chicago.

HEIDENREICH, JAMES C., to Alfred E. Maffly, administrator of Herrick Memorial Hospital, Berkeley, Calif.

JOHNSON, EMMETT R., to Lawrence Payne, administrator of East



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WASHINGTON University students of hospital administration completing academic work for master's degrees are (first row, left) Warren Simonds, Dora Belle Ford, Leonard Thompson, Charles Goff, Eugene Edwards, (second row, left) Roderic Bell, Dorothy Hagedon, Augustin Diaz, George Stafford, Harry Panhorst (associate director), (third row, left) Dr. Frank R. Bradley (director), Neil Wortley, Frank Schwermin, Wilbur Birthelmer, (fourth row, left) James Canedy, Frederick Marshall, Charles Lohr, Edwin Campbell and Roland Lea.

Texas Hospital Foundation, Tyler.

KEISER, PAUL H., to Ralph M. Hueston, superintendent of Wesley Memorial Hospital, Chicago.

KRAMER, WILLIAM J., to Dr. J. A. Katzive, director of Mount Zion Hospital, San Francisco.

LINDHORST, ELLIS H., to S. A. Ruskjer, deputy director of health in charge of hospitals, Louisville and Jefferson County, Louisville, Ky.

LUTHER, OSCAR D., to Dr. A. C. Kerlikowske, director of University of Michigan Hospital, Ann Arbor.

MANSFIELD, EDGAR O., to J. C. Byrd, administrator of Mound Park Hospital, St. Petersburg, Fla.

NILAJGI, YESHWANT M., to Edgar C. Hayhow, Ph.D., director of East Orange (N.J.) General Hospital.

PERRY, ANTHONY J., to Leon C. Pullen Jr., administrator of Decatur and Macon County Hospital, Decatur, Ill.

PETERSON, HAROLD L., to Dr. A. F. Branton, administrator of Baroness Erlanger Hospital, Chattanooga, Tenn.

PINDIAK, STEVEN C., to Norman L. Losh, administrator of Orange Memorial Hospital, Orlando, Fla.

RHEE, JURRAL C. P., to Arthur J. Will, superintendent of charities, Los Angeles County, Calif.

DR. ALBERT W. SNOKE, director of the Grace-New Haven Community Hospital and professor of hospital administration at Yale University, discusses hospital construction with eight hospital administration students and the winners of the Magnus T. Hopper fellowship in hospital architecture. They are (seated, from left) Richard B. Ogrean, Joanna A. Henry, Dr. Snoke, George S. Buis (director of the course), Sister Mary Florentia Srader, Naomi Bitz, (standing, from left) Robert F. Tuveson, J. Wilder Green, Manual Cohen, Warren A. Peterson, Richard S. Nutt, Chia-Yi Jen, Raymond J. Reynolds and Arnold Mogenson. Mr. Green, Mr. Peterson, Mr. Jen and Mr. Mogenson are the fellowship winners.

RUNDLE, WILLIAM R., to David A. Endres, superintendent of Youngstown (Ohio) Hospital.

SCHREI, ELIZABETH J., to Eva H. Erickson, administrator of Galesburg (Ill.) Cottage Hospital.

SHEDLOVSKY, RICHARD, to William S. Brines, director of The Malden (Mass.) Hospital.

SHOWALTER, CHARLES, to Norman L. Losh, administrator of Orange Memorial Hospital, Orlando, Fla.

SLEDGE, ELBERT B., to Frank S. Groner, administrator of Baptist Memorial Hospital, Memphis.

SODT, PAUL T., to Jack A. L. Hahn, administrator of Memorial Hospital of Sandusky County, Fremont, Ohio.

TAYLOR, DOYLE R., to Bruce Dickson, administrator of Bethany Hospital, Kansas City, Kan.

WALLS, GEORGE F., to J. Stanley Turk, administrator of Ohio Valley General Hospital, Wheeling, W. Va.

WHELAN, ANNE M., to Edna H. Nelson, administrator of Women and Children's Hospital, Chicago.

UNIVERSITY OF PITTSBURGH

BARQUIN, MANUEL C., M.D., to the U. S. Marine Hospital, New Orleans (master of public health degree).

ELLIOTT, GORDON W., to Charles C. Stewart, superintendent of Mercer Hospital, Trenton, N. J. (master of science degree).

FITZPATRICK, THOMAS B., to Sidney M. Bergman, executive director of Montefiore Hospital, Pittsburgh (master of science degree).

GRATZ, CHARLES, appointment pending (master of science degree).

KAHLE, VAUGHN D., to Morris F. George, executive director of Abington (Pa.) Memorial Hospital (master of science degree).

KIMES, WILLIAM J. JR., to Sidney M. Bergman, executive director of Montefiore Hospital, Pittsburgh (master of science degree).

LARSEN, FRANK L., to Richard R. Griffith, director of the Delaware Hospital, Wilmington, Del. (master of science degree).

MAYER, JAMES J., to Richard F. Seifert, administrator of Lee Hospital, Johnstown, Pa. (master of science degree).

SPRINGER, RICHARD D., to J. Stanley Turk, administrator of Ohio Valley General Hospital, Wheeling, W. Va. (master of science degree).

SAINT LOUIS UNIVERSITY

AMIEIRO, MOISES, to Dr. J. C. Mackenzie, director of Touro Infirmary, New Orleans.

BARBERA, EUGENE, to Orville N. Booth, administrator of St. Francis Hospital, San Francisco.

DIRKSEN, REV. FRANK, to Sister M. Andrea, administrator of De Paul Hospital, St. Louis.

FOLEY, JOHN W., to Sister Bernard Mary, administrator of St. Francis Hospital, Hartford, Conn.

HALLIGAN, SISTER MARY LAWRENCE, to Sister M. Harriet, superintendent of St. Mary's Hospital, Minneapolis.

HINTON, WARREN S., to Dr. David Littauer, director of Menorah Hospital, Kansas City, Mo.

HOLTERS, ROBERT W., to Anthony W. Eckert, director of Perth Amboy (N.J.) General Hospital.

LANG, LOUISE M., to Harold K. Wright, superintendent of Methodist Hospital, Sioux City, Iowa.

LINNEMANN, SISTER MARY ALBERT, to Sister M. Inez, administrator of St. Mary's Hospital, Rochester, N. Y.

SCHUMACHER, PHILIP K., to Dr. Robert H. Lowe, medical director of Rochester (N.Y.) General Hospital.

SHYNE, IGNATIUS JOSEPH, to Florence King, administrator of Jewish Hospital, St. Louis.

WHALEN, THOMAS HARRISON, to LeRoy C. Brown, superintendent of Stamford (Conn.) Hospital.

ZINKAND, SISTER MARY THOMAS, to Sister M. Inez, administrator of St. Mary's Hospital, Rochester, N. Y.

ZUBER, FREDERICK J., to Sister M. Dorothea, administrator of Loretto Hospital, Chicago.

UNIVERSITY OF TORONTO

DAESCHEL, WERNER, to R. Fraser Armstrong, general superintendent of Kingston (Ont.) General Hospital.

DILLON, HAROLD, to Dr. Carman J. Kirk, superintendent of Victoria Hospital, London, Ont.

DONEY, J. JR., to Col. C. C. Hillman, M.D., director of Jackson Memorial Hospital, Miami, Fla.

FRASER, MICHAEL, to George E. Masters, director of Royal Jubilee Hospital, Victoria, B. C.

HEAPS, PHILIP, to A. J. Swanson, general superintendent of Toronto (Ont.) Western Hospital.

MACKAY, J., to W. E. Leonard, superintendent of Toronto East General and Orthopedic Hospital.

NABERT, EDWIN, to G. Friesen, administrator of Kitchener-Waterloo Hospital, Kitchener, Ont.

NICHOL, WILLIAM, to Leon N. Hickernell, director of Vancouver (B.C.) General Hospital.

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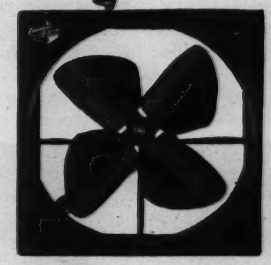

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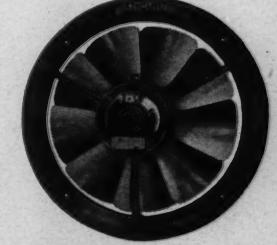

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RADEY, HARVEY JR., to John F. Crane, director of Paterson (N.J.) General Hospital.

ROSS, HUGH, to R. J. Weatherill, superintendent of St. Catharines (Ont.) General Hospital.

SHORTLIFFE, ERNEST, M.D., to Dr. Angus C. McGugan, superintendent of University of Alberta Hospitals, Edmonton.

YALE UNIVERSITY

BITZ, NAOMI, to Dr. Clement C. Clay, director of Orange (N.J.) Memorial Hospital (master of public health degree).

COHEN, MANUEL, to Dr. Martin Cherkasky, director of Montefiore Hospital, New York City (master of science degree).

HENRY, JOANNA ADELE, to Dr. Philip D. Bonnet, administrator of Massachusetts Memorial Hospitals, Boston (master of public health degree).

NUTT, RICHARD SHERMAN, to Dr. Edward M. Bernecker, administrator of New York University Hospital, New York City (master of science degree).

OGREAN, RICHARD BERTON, to Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital, New Haven, Conn. (master of science degree).

REYNOLDS, RAYMOND JULIUS, to Dr. Dean Clark, executive director of Massachusetts General Hospital, Boston (master of public health degree).

SRADER, SISTER MARY FLORENTIA, to Sister Anne Lucy, administrator of St. Mary's Hospital, Tucson, Ariz. (master of public health degree).

TUVESON, ROBERT FRED, to Dr. Eugene Walker, superintendent of the Springfield (Mass.) Hospital (master of science degree).

Northwestern Graduates

Forty-five degrees of master of hospital administration and two degrees of bachelor of science in hospital administration were conferred upon graduates of Northwestern University in June. Since the beginning of the course in 1943, degrees in hospital administration have been awarded to 216 students.

The recipients of master's degrees are:

AMICARELLA, HENRY, administrative assistant at Colorado General Hospital, Denver.

ARREAZA COLIZZA, NESTOR M., M.D., to be administrator of a hospital in Valencia, Venezuela.

AXELSON, NILS G., completing administrative residency at East Orange (N.J.) General Hospital.

BARDEN, NORMA M., administrative assistant, Philadelphia General Hospital.

BLYTHE, HARRY A., assistant superintendent, University of Chicago Clinics, in charge of operation of the Argonne Cancer Research Hospital.

CARLISLE, BENNY T., administrator of a hospital in Crossville, Ky.

CIPALA, MARIAN F., completing administrative residency at Jefferson-Hillman Hospital, Birmingham, Ala.

GETTMAN, JOHN C., assistant administrator of Memorial Hospital of Sandusky County, Fremont, Ohio.

GIESE, STANLEY E., administrator of Warren Hospital, Michigan City, Ind.

HALL, DWAYNE L., administrator of City Hospital, Bowling Green, Ky.

HIGGINS, HARRY G. JR., formerly business manager of Miami Valley Hospital, Dayton, Ohio.

HILL, WALDO A., administrative assistant at Baylor University Hospital, Dallas.

JACOBSON, ROBERT T., completing administrative residency at Baroness Erlanger Hospital, Chattanooga.

LETOURNEAU, CHARLES U., M.D., secretary, Council on Professional Practice, American Hospital Association.

LILLI, JOSEPH A., assistant administrator of Citizens General Hospital, New Kensington, Pa.

MCHUGH, RAYMOND T., administrative assistant at Herrick Memorial Hospital, Berkeley, Calif.

MAY, FREEMAN E., administrator of Le Bonheur Children's Hospital, under construction in Memphis.

MOBURG, KENNETH D., completing administrative residency at Grace Hospital, Detroit.

MONARDO, GEORGE D., completing administrative residency at Los Angeles County Hospital.

NICHOLS, MARVIN W., administrative assistant at Methodist Hospital, Sioux City, Iowa.

OBERG, ALBIN H., assistant administrator, Malden (Mass.) Hospital.

QUITTMEYER, ERNEST W., completing residency at Passavant Memorial Hospital, Chicago.

RYBERG, ERNEST A., master's degree awarded posthumously; formerly administrator of Anna (Ill.) City Hospital.

SANDAHL, ROBERT A., assistant administrator, Wausau (Wis.) Memorial Hospital.

SCALZO, DONALD F., assistant administrator, Evangelical Hospital, Chicago.

SEJNOST, RICHARD L., administrative assistant at Harper Hospital, Detroit.

SMITH, CARLOS J. R., assistant administrator at Methodist Hospital, Memphis.

WEINZETTEL, ROY J., assistant administrator, Mound Park Hospital, St. Petersburg, Fla.

WHEELER, OTIS L.

THE ELEVEN residents graduated from the University of Chicago are (front row, left) William James Daniels, Harry Norbert Dorsey, Rodger Carl Johnson, James Murray Taylor, Lester Roberts, (back row, left) Elton Taft Ridley, John Clawson Imhoff, Bernard Eugene Lorimer, Brady Lee Mootz, Robert Charles Hardy. Walter Pierce Allen is not in the picture.

WICKHAM, MED, with 5th Evacuation Hospital, United States Army, Fort Bragg, N. C.

WILKONSON, LOUISE, administrator (since 1949) of San Jacinto Memorial Hospital, Baytown, Texas.

YOTHERS, LEE W., completing administrative residency at Research and Educational Hospitals, University of Illinois, Chicago.

ZIMMERMAN, MORTIMER W., personnel and public relations director, Passavant Memorial Hospital, Chicago.

The following students qualified for master's degrees last August but received them last month:

AUSTIN, MAJ. WILLIAM L., M.S.C., at hospital administration school, Brooke Army Medical Center, Fort Sam Houston, Texas.

DANDIGNAC, REV. J. GORDON, administrator of Dickinson County Memorial Hospital, Iron Mountain, Mich.

DISMUKES, COL. JACKSON B., M.C., post surgeon and commanding officer, United States Army Hospital, Camp Polk, La.

GONZALEZ-MORA, JOSE, M.D., representative of the hospital department, American College of Surgeons, Chicago.

JOBE, COL. LOUIS H. JR., M.C., with United States Army in Austria.

LIEN, DIN SHIANG, graduate student, University of Illinois.

MCCLEARY, COL. GORDON F., M.S.C., hospital administration school, Brooke Army Medical Center, Fort Sam Houston, Texas.

POTTER, REV. PAUL KENNETH, chaplain, United States Navy.

RECKNAGEL, MILDRED L., formerly assistant administrator of Springfield (Ill.) City Hospital.

SCHROEDER, JOHN B., business manager, Rock Island City Convalescent Home, Coal City, Ill.

STUART, EUGENIE M., assistant professor of hospital administration, University of Toronto.

VEIGEL, COL. LESTER P., M.C., consultant in hospital administration, office of the surgeon general, United States Air Force.

Bachelor's degrees were conferred on:

LYNCH, FRANK A., manager of patient services, St. Luke's Hospital, Chicago.

QUINN, JAMES W., assistant administrator, Jefferson-Hillman Hospital, Birmingham, Ala.

Johns Hopkins Graduates

A class of five students in hospital administration was graduated

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from the school of hygiene and public health at Johns Hopkins University during June. The graduates, all receiving the degree of master of public health, are Wilbur Charles Anderson, Pennsylvania; Jane Carol Baldwin, Maryland; Barry Bowers, New Jersey; Clifford Stanley Johnson, District of Columbia, and Dr. Rafael Lorca, Chile, South America.

Award Winners

Awards for outstanding work were given to two graduate students in hospital administration at Northwestern University. Both received their master's degrees in June.

Mortimer W. Zimmerman, personnel and public relations director of Passavant Memorial Hospital, Chicago, is the winner of the Malcolm T. MacEachern award, consisting of a silver medal and a $250 honorarium.

The Mary H. McGaw award, consisting of $200, was given to Albin H. Oberg, assistant administrator of Malden (Mass.) Hospital.

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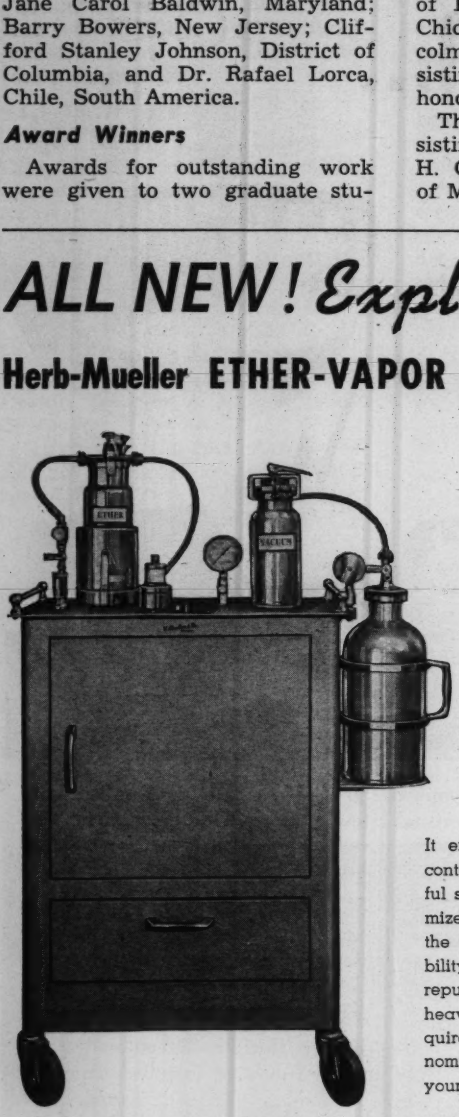

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In its entirety, this new Herb-Mueller Explosion-Proof Ether-Vapor and Vacuum Unit is listed under the Re-examination Service of Underwriters' Laboratories, Inc., as suitably safe for use in hazardous locations, Class I, Group C . . . Twin pumps create vacuum to 25 inches of mercury, spray pressure to 15 pounds . . . Operation is noiseless, vibration-free . . . Reinforced steel cabinet rolls on 4" conductive rubber casters . . . Fully visible quart and gallon suction bottles have quick-change tops.

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· GENERAL ·

Hospital Service

During the past year 318 new hospitals have been registered by the American Medical Association. Counterbalancing these were the closing of 161 hospitals, resulting in a total registration of 6,729 hospitals in the United States and its possessions.

The association's May 12 JOURNAL discloses that 824 hospitals have been approved for interns and 1,102 offer residency training on an approved basis. A total of 1,292 hospitals have been approved by the American Medical Association for the training of interns and/or residents.

Accredited professional schools of nursing function at 1,106 hospitals and 220 hospitals offer acceptable affiliated training.

American Medical Association survey of hospital service
United States, 1950

	All Registered Hospitals	General Hospitals
Number	6,430	4,713
Bed capacity	1,456,912	587,917
Bassinets	89,200	85,582
Patients admitted	17,023,513	15,830,170
Births	2,815,806	2,739,212
Average daily census	1,242,777	433,364
Patient days	453,613,605	158,177,860

Source: *Journal of the American Medical Association*, May 12, 1951.

Aid for Medical Schools

Financially distressed medical schools in the United States will receive assistance from a recently established philanthropic organization, the National Fund for Medical Education.

The undertaking, announced by former President Herbert Hoover, has the backing of industry, the medical profession, organized labor, agriculture, a group of university presidents and 12 scientific and educational foundations.

A recent report revealed that a minimum of an additional $40,000,00 a year is needed to cover the medical schools' operating expenses at present enrollment levels.

The administrative costs of the fund have been underwritten by 12 foundations, making it possible for all contributions to be used directly for medical education.

Birth Weight Statistics

Development of birth weight statistics on premature births and neonatal mortality, comparable from state to state, is expected for the first time as a result of a statement "Recommendations for Developing Comparable Statistics on Prematurely Born Infants and Neonatal Mortality" issued by the Public Health Conference on Records and Statistics, Association of Maternal and Child Health and Crippled Children Directors, Children's Bureau and the National Office of Vital Statistics of the Federal Security Agency.

An introduction to the statement points out that there has been a marked reduction in infant mortality in the last few decades, but there still is a need for intensified investigation of factors related to immaturity, the condition associated with most of the deaths of early infancy.

Radio Star Visits Hospital

Virginia Kaye, star of the daytime radio serial, "Rosemary," which currently is featuring a contest on "What our community hospital means to me," is shown (standing) during a recent trip to St. Vincent's Hospital, New York City. Local Columbia Broadcasting System radio stations are handling all details of the contest and in many cases have contacted hospital administrators, hospital councils and health and civic leaders in the community to assist in judging contest entries. Full details of the contest appeared on page 58 of HOSPITALS for June, Part I.

Medical Education in 1950

Reports from medical examining boards on the number of examinations and licenses issued in 1950 are the basis of the state board issue of the *Journal of the American Medical Association,* dated May 26. The issue summarizes trends during recent years in medical licensure, the requirements of each licensing board in the United States and territories, and the number of successful graduates and failures on the state board examinations from the various medical schools.

The following figures illustrate the increased number of physicians.

Licenses issued	12,209
Issued by written examination	5,454
Issued by reciprocity	6,755
First licenses granted	6,002
Physician mortality	3,794
Net increase in physician population	2,208

Flower Rooms Donated

The Kansas City Floral Industries Association, comprised of 162 retailers, wholesalers and growers, will contribute 20 flower rooms to the Baptist Memorial Hospital to be constructed in Kansas City, Mo.

Oily lotion helps prevent bed sores

The soothing, emollient character of Dermassage has made it a confirmed ally in measures for the prevention of bed sores and in massage. Its lanolin and olive oil content lubricates skin surfaces and reduces the likelihood of skin cracks and irritation resulting from dryness. A pleasant cool sensation is produced by menthol, without resort to rapid evaporation and loss of skin moisture.

Hexachlorophene gives added protection

With the addition of hexachlorophene, effective germicidal and deodorant agent of low toxicity, Dermassage has acquired greater protective value. It makes possible a lowered bacterial count on skin areas to which it is routinely applied, thus minimizing the risk of initial infection should skin breaks occur in spite of precautions.

An efficient means of protecting the patient against skin discomfort or damage while confined to bed or wheel chair in hospital or home. Used and approved in thousands of hospitals, coast-to-coast, and on the recommendation of doctors, nurses and hospitals to patients returning home.

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AMA Approval for Accreditation

The proposed cooperative program for hospital accreditation, to be operated jointly by the American Hospital Association, the American Medical Association, the American College of Surgeons and the American College of Physicians, was approved by the American Medical Association at its 100th convention last month.

The action of the association's house of delegates was not too clear, but when the session was over accreditation had been approved, with the suggestion that the American Medical Association's board of trustees see what can be done toward modifying the composition of the joint commission that will administer the program and establishing an advisory committee with broad representation of medical specialty interest.

The basic plan of organization already has been approved by the American College of Surgeons and the American College of Physicians. The American Hospital Association has approved in principle the establishment of an accreditation program, and details of the current proposal will be presented for approval at the St. Louis convention in September.

Publicity: The association voted to retain the consultive services of the public relations firm of Whitaker and Baxter for an additional year. This firm has been conducting the medical profession's campaign against federal compulsory health insurance.

Public views: Another decision of the association was to appoint a committee of prominent laymen to advise it in matters of medical care and "to present the viewpoint of the general public."

Officers: Dr. Louis H. Bauer, Hempstead, N. Y., chairman of the board of trustees, was chosen as president-elect of the association. Next year he will succeed Dr. John W. Cline of San Francisco, who was installed last month. The retiring president is Dr. Elmer L. Henderson of Louisville, Ky.

Catholic Association

The Rt. Rev. Msgr. John J. Healy, diocesan director of hospitals for Little Rock, Ark., and a trustee of the American Hospital Association, was installed as president of the Catholic Hospital Association at its annual convention June 2-5 in Philadelphia. He succeeds the Rt. Rev. Msgr. John R. Mulroy of Denver.

The Rt. Rev. Msgr. Charles A. Towell, diocesan director of hospitals, Covington, Ky., was named president-elect. First and second vice presidents are, respectively, the Rev. Francis P. Lively, associate director of the division of health and hospitals, diocese of Brooklyn, and the Rt. Rev. Msgr. Robert A. Maher, diocesan director of hospitals, Toledo. Msgr. Maher was third vice president of the Ameri-

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can Hospital Association in 1949-50. Sister Martha Mary, St. Clare's Hospital, New York City, was re-elected secretary, and Sister Mary Seraphia, St. Louis, was re-elected treasurer.

Newly elected to the executive board are Sister Catherine Gerard, Halifax (Nova Scotia) Infirmary, and Mother Margaret Mann, Grey Nuns' Provincial House, St. Boniface, Manitoba. Re-elected to the board are Sister Fidelis, administrator of St. Joseph's Infirmary, Houston, Texas; Sister Mary Hilary, administrator of Holy Cross Hospital, Salt Lake City; Sister Lydia, administrator of St. Vincent's Hospital, Indianapolis, and Sister Mary Veronica, superintendent of Mercy Hospital, Baltimore.

The sessions of the four-day convention were planned on the overall theme "The Responsibility of the Catholic Hospital in Critical Times." Principal speakers at the general sessions were Dr. Charles Wilinsky, president of the American Hospital Association, who discussed the place of the voluntary hospital in the emergency; Dr. Howard A. Rusk, chairman, Health Resources Advisory Committee, who spoke on "Assuring Adequate Professional Staffing for Civilian Hospitals"; the Rt. Rev. Msgr. Paul Tanner, assistant executive secretary of the National Catholic Welfare Conference, whose subject was "Marshalling Spiritual Resources," and Dr. Marcus Kogel, commissioner of health, New York City, speaking on community planning for disaster. A panel discussion on "Increasing Religious Personnel in Catholic Hospitals Through Vocations" was led by the Rev. Richard Rooney, S. J., of *Queen's Work* magazine, St. Louis.

MSGR. HEALY

Maritime

Neil MacLean, Charlottetown, P.E.I., was elected president of the Maritime Hospital Association at its annual meeting June 5-7 in St. Andrews, N. B. He succeeds A. D. McInnis, Antigonish, N. S.

Outstanding among business conducted at the meeting was the establishment of a program for improved Blue Cross-hospital financial relations, whereby the association will take the initiative in working with hospitals accused by the Maritime Blue Cross plan of billing it for exorbitant charges. Full details of this significant development in Blue Cross-hospital relationships are in the prepaid section of the news department.

Other officers elected at the Maritime meeting are the first vice president, Dr. O. C. MacIntosh, Antigonish, N. S.; second vice president, Col. Leo D. MacDonald, Charlottetown, P.E.I.; third vice president, Ralph H. Gale, superintendent of Saint John (N. B.) Gen-

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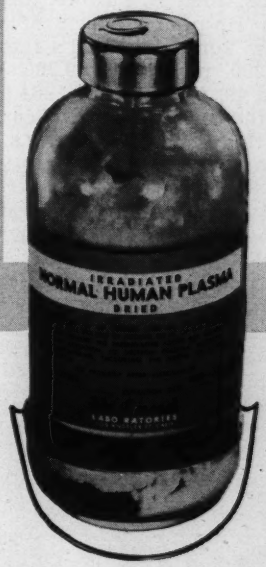

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PICTURED with Sister Mary Jude, immediate past president of the New Mexico Hospital Association and administrator of the St. Joseph Sanatorium and Hospital in Albuquerque, are three of the association's new officers, elected at the annual convention in May: (from left) P. W. McFarland, president-elect; F. O. Foley, president, and R. W. Bashaw, trustee.

eral Hospital, and the secretary-treasurer, Mrs. Gladys M. Porter, Kentville, N. S.

Pennsylvania Regional

A. C. Seawell, superintendent of Pottstown Hospital, was elected president of the Eastern Regional Hospital Association of Pennsylvania at a meeting in April at Sellersville.

Vice president is R. L. Suck, assistant manager of St. Luke's Hospital, Bethlehem, and secretary-treasurer is Ray T. Kern, Allentown Hospital.

Middle Atlantic

Convening in Atlantic City May 23-25, the Middle Atlantic Hospital Assembly elected as president Anthony W. Eckert, director of Perth Amboy (N. J.) General Hospital.

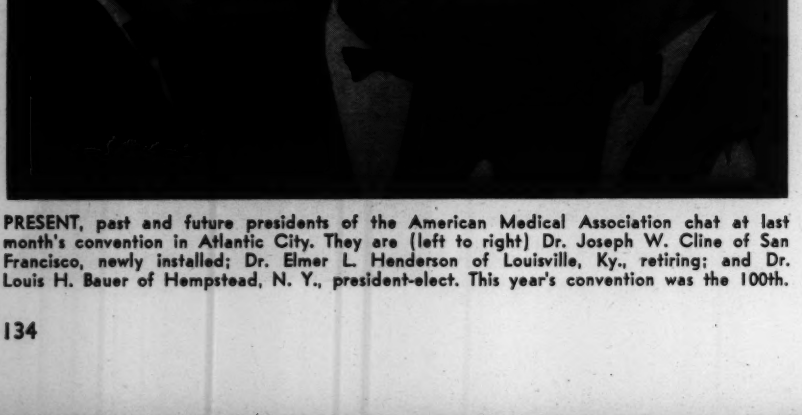
Other officers are: Vice president, Carl P. Wright, executive secretary, Hospital Association of New York State, and superintendent of Woman's Hospital, New York City; treasurer, John F. Worman, executive secretary of the Hospital Association of Pennsylvania; and secretary, J. Harold Johnston, executive director of the New Jersey Hospital Association.

Approximately 1,775 persons registered for the convention to attend the meetings and to view the 140 booths of hospital supplies and equipment.

Dr. John B. Pastore, director of the Hospital Council of Greater New York, estimated a shortage of 22,200 physicians, 9,200 dentists and 49,200 nurses by 1954 in a talk to the conventioners. (See page 80 of this issue of HOSPITALS.)

New Mexico

F. O. McVey, superintendent of Clovis Memorial Hospital, was installed as president of the New Mexico Hospital Association at the annual meeting May 18-19 in Santa Fe. The new president-elect is P. W. McFarland, superintendent of Espanola Hospital; vice-president, Sister Catherine Lorraine, R.N., superintendent of St. Anthony's Hospital, Las Vegas; secretary-treasurer, Rusha Smith, Clovis Memorial Hospital. The re-elected trustees are R. W. Bashaw, administrator of the Carrie Tingley Hospital, Truth or Consequences, and Mary Young, administrator of Miners Hospital, Raton.



PRESENT, past and future presidents of the American Medical Association chat at last month's convention in Atlantic City. They are (left to right) Dr. Joseph W. Cline of San Francisco, newly installed; Dr. Elmer L. Henderson of Louisville, Ky., retiring; and Dr. Louis H. Bauer of Hempstead, N. Y., president-elect. This year's convention was the 100th.

Upper Midwest

The Upper Midwest Hospital Conference, held May 16-18 in Minneapolis, was attended by 3,013 persons.

Harry C. Wheeler, administrator of Billings (Mont.) Deaconess Hospital, was elected president, succeeding Harold Wright, superintendent of Methodist Hospital, Sioux City, Iowa.

Other officers are: Vice president, O. M. Nelson, credit department, Sioux Valley Hospital, Sioux Falls, S. D., and secretary-treasurer, Glen Taylor, business manager, Students' Health Service, University of Minnesota.

More than 160 commercial and educational booths were on view in the exhibition hall at the convention. General sessions during the three-day program included talks and discussions on civilian defense, federal legislation involving hospitals, medical staff and the hospital, nursing and Blue Cross. Sectional meetings were held by associations of dietitians, nurse anesthetists, women's auxiliaries, national executive housekeepers, trustees, pharmacists, medical and institutional librarians, medical social workers, medical technologists, medical record librarians, and occupational therapists.

Indiana

The Indiana Hospital Association convened May 23-24 at French Lick Springs and elected as president Sister Mary Ellen, purchasing agent of St. John's Hickey Memorial Hospital in Anderson.

President-elect is Edmund J. Shea, assistant administrator of Indiana University Medical Center, Indianapolis; vice president, Mrs. Fred Raison, administrator of Johnson County Hospital, Franklin; executive secretary, Albert G. Hahn, administrator of Protestant Deaconess Hospital, Evansville; assistant to the secretary, Mrs. Albert G. Hahn, Protestant Deaconess Hospital, Evansville, and treas-

urer, Maude M. Woodard, superintendent of Clinton County Hospital, Frankfort.

Arkansas

Kenneth Newman, director of administration of University Hospital, Little Rock, was inducted as president of the Arkansas Hospital Association during the organization's twenty-first annual convention held May 15-16 in Hot Springs.

Other officers are: President-elect, John A. Rowland, business manager of Trinity Hospital, Little Rock; vice president, Sister Rita Rose, administrator of Rogers Memorial Hospital; treasurer, George Berryman, administrator of the Washington County Hospital, Fayetteville; secretary, Eugene Lopez, administrator of Community Methodist Hospital, Paragould, and trustee, J. S. Hancock, Drew County Memorial Hospital, Monticello.

A state hospital auxiliary with Mrs. J. M. Flenniken of Little Rock as president was formed during the convention.

Albert V. Whitehall, director of the Washington Service Bureau of the American Hospital Association, spoke on "Trends in Hospital Care." The state associations of nurse anesthetists, dietitians, and medical record librarians convened during the two-day meeting of the association.

New Jersey

The New Jersey Hospital Association inducted as president W. Malcolm MacLeod, superintendent of Elizabeth General Hospital, at its thirty-fourth annual convention, in Atlantic City on May 24.

Other officers are: President-elect, William B. Meytrott, administrator of the William McKinley Memorial Hospital, Trenton; and vice president, Robert G. Boyd, administrator of Morristown Memorial Hospital. Howard S. Lyon, president of the Somerset Hospital in Somerville for several years, who was to be treasurer of the association for the coming year, died two days before the convention. J. Howard Buzby, president of the Atlantic City Hospital, has been appointed treasurer by the board

The association presented a certificate to Emil Frankel, director of the research division of the State Department of Institutions and Agencies, and made him an honorary member. Mr. MacLeod, on behalf of the association, presented a citation to the Perth Amboy General Hospital for its service to victims of the South Amboy explosion and Woodbridge train wreck.

RECENTLY elected officers of the Indiana Hospital Association for 1951-52 are: (left) executive secretary, Albert G. Hahn; president, Sister Mary Ellen; president-elect, Edmund J. Shea; treasurer, Maude M. Woodard. Mrs. Fred Raison, vice president, is not shown.

New York

F. Wilson Keller, director of the Hospital for Special Surgery, New York City, was elected president of the Hospital Association of New York State at the annual convention in May in Atlantic City.

Other officers elected are: First vice president, Dorothy Pellenz, superintendent, Crouse-Irving Hospital, Syracuse; second vice president, J. Russell Clark, director, Brooklyn Hospital; secretary, Carl P. Wright Sr., superintendent, General Hospital, Syracuse, and treasurer, M. P. Tanner, director, Children's Hospital, Buffalo.

Pennsylvania

E. Atwood Jacobs, administrator of the Reading Hospital, was elected president of the Hospital Association of Pennsylvania at its annual meeting May 24.

Other officers elected are: First vice president, Charles S. Paxson Jr., superintendent, Delaware County Hospital, Drexel Hill; second vice president, Arthur H. Brittingham, administrator of Easton Hospital, and treasurer, Robert W. Gloman, administrator of Wilkes-Barre General Hospital. John F. Worman, Harrisburg, was reappointed executive secretary.

ARKANSAS Hospital Association officers for 1951-52 are: (first row, left) president, Kenneth Newman; vice president, Sister Rita Rose; president-elect, John A. Rowland; (back row, left) treasurer, George Berryman; trustee, J. S. Hancock; secretary, Eugene Lopez.

Tuberculosis Association

Frederick D. Hopkins, executive secretary of the National Tuberculosis Association, has been succeeded in his job by James G. Stone, according to an announcement last month in the New York *Times*.

Mr. Hopkins' retirement terminates 36 years' work on the staff of the association. He became administrative secretary in 1920, and his title was later changed to executive secretary.

Mr. Stone has been director of program development for eight years. In 1936 he became executive secretary of the Los Angeles Tuberculosis and Health Association and joined the national staff in 1943.

West Virginia

Paul J. Mehlinger was installed as president of the West Virginia Hospital Association at the annual meeting of the group held during April. Mr. Mehlinger is administrator of Monongalia General Hospital in Morgantown.

During the elections held at that time Blair M. Patterson, administrator of St. Luke's Hospital, Bluefield, was named president-elect. Other officers are the vice president, Thomas Bess Jr., administrator of Potomac Valley Hospital, Keyser, and secretary-treasurer, J. Stanley Turk, administrator of Ohio Valley General Hospital, Wheeling.

Heart Association Officers

Dr. Louis N. Katz, director of cardiovascular research at Michael Reese Hospital, Chicago, has been elected president of the American Heart Association succeeding Dr. Howard B. Sprague, Brookline, Mass., who has assumed chairmanship of the association's scientific council.

Dr. Irving S. Wright, professor of clinical medicine, Cornell University, was chosen president-elect. Five vice presidents were elected instead of the usual one. They are Mrs. Alben Barkley, wife of the vice president of the United States; Bruce Barton, chairman of the board of a New York advertising agency; T. Duckett Jones, M.D., chairman of the American Council on Rheumatic Fever; Robert L. King, M.D., the Mason Clinic, Seattle, and Frederick K. Trask Jr., New York business man.

The election took place at the annual convention of the association last month in New York.

Approximately $5,300,000 has been raised through public contributions to the 1951 heart fund to support the attack against heart diseases, Dr. Sprague announced. The total is incomplete pending final accounting from several areas.

New Mexico Director Resigns

Reginald F. Cahalane, who has resigned as director of Hospital Service, Inc., the Blue Cross plan of New Mexico, in Albuquerque, has been succeeded by C. Robin Jacobsen, who will also serve as director of Surgical Service, Inc., surgical prepayment plan.

Mr. Jacobsen has had five and one-half years of experience in the Blue Cross field, mostly with the Massachusetts Hospital Service. He has been with the New Mexico plan since October 1950, serving as director of hospital and professional relations.

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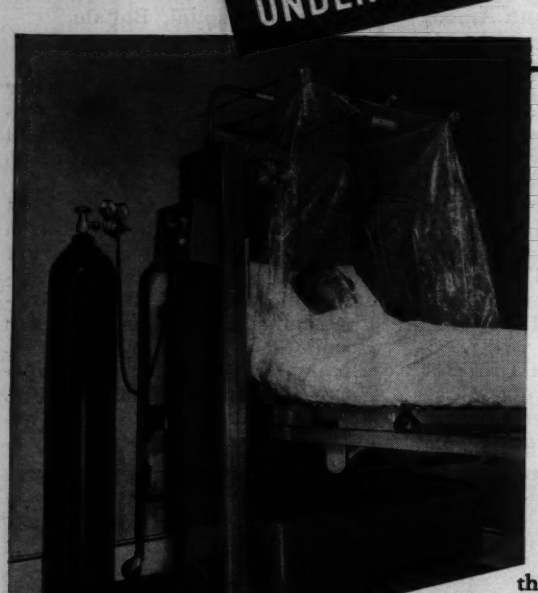

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Modern Mental Hospital

Michael Reese Hospital's new Institute for Psychosomatic and Psychiatric Research and Training was dedicated June 2 in Chicago.

The institute, built at a cost of $2,000,000, has a capacity of 82 patient beds and is the first major hospital building for patients to be completed in the long range enlarged medical center plans of Michael Reese Hospital.

One of the purposes of the institute is the teaching of much-needed trained personnel: Resident physicians training to become psychiatrists; medical students, social workers, nurses, occupational therapists, psychologists, and interns, residents, and staff doctors in other specialties on the Michael Reese Hospital staff.

SCALE model of the Michael Reese addition.

The institute has been designed to permit the addition of two more floors. There are day rooms for handicraft work and gardens for outdoor activities. On each floor there are treatment rooms and offices where patients can be interviewed and treated in complete privacy.

Michael Reese in 1922 became one of the first general hospitals in the country to start a community psychiatric clinic, and in 1939 the hospital opened a 22-bed psychiatric unit within the hospital. There are only about 300 general hospitals in the United States having any psychiatric facilities, which usually are small units. The shortage of beds for psychiatric patients in general hospitals, therefore, is particularly acute.

Medical Research Center

The cornerstone of the Public Health Service's new Clinical Center for medical research at Bethesda, Md., was laid by President Harry S. Truman on June 22. The 500-bed structure is a new addition to the National Institutes of Health, north of Bethesda.

Construction of the Clinical Center was authorized by Congress in 1947 and begun in the autumn of 1948. It will be completed in 1952 at an estimated cost of $40,000,000.

Dr. Leonard A. Scheele, surgeon general of the Public Health Service, described the center as "the only combined laboratory-hospital in the world especially designed for research on a group of important chronic diseases—cancer, heart disease, mental, metabolic and neurological diseases."

Dr. John A. Trautman, formerly medical officer in charge of the Public Health Service's Marine Hospital, Staten Island, N. Y., has been appointed director of the Clinical Center. With 22 years of experience in the Public Health Service, Dr. Trautman has held offices in Marine hospitals of the Public Health Service in New Orleans, San Francisco and Cleveland.

He succeeds Dr. Jack Masur, who recently was appointed assistant surgeon general and chief of the Bureau of Medical Services.

Recent Dedications

Three hospital dedications have taken place recently.

The new Greene Memorial Hospital was dedicated in Xenia, Ohio, as a memorial to local veterans of all American wars.

The 79-bed hospital was begun in 1947 and completed at a cost of $1,383,000. Superintendent is Omer B. Maphis.

Greenwich (Conn.) Hospital last month dedicated its new patients' unit that has accommodations for 211 patients and ancillary facilities to adequately serve a hospital of 400 beds.

The cost of the building program, carried on during the last 10 years, was $4,750,000. This includes conversion of the old structure to outpatient clinics and a nurses' school and residence.

William J. Donnelly is administrator of the hospital, which recently affiliated with the New York University-Bellevue Medical Center's regional hospital plan. The American Medical Association has approved the hospital for intern training.

Dedication of the new Cancer Research Institute of New England Deaconess Hospital, Boston, took place in June. The institute will provide cancer research, atomic research, cancer control and diagnosis, and outpatient department tumor clinics.

Included in the dedication will be the Elliott P. Joslin Auditorium, part of the new building. The auditorium will be used for teaching.

Dr. Warren F. Cook, executive director of the hospital, announced that the institute is the first part of a $5,000,000 building program at Deaconess Hospital. Already under construction is the new Central Deaconess Building, centralizing all operating facilities, laboratories, x-ray and kitchens.

Hospital Inventory

An inventory of hospitals and related facilities in New York City has been released by the Hospital Council of Greater New York.

According to the report, issued annually, 33,374 general care beds were available as of Jan. 1, 1951, in the New York City hospitals. The total is only 226 beds less than the number recommended by the Hospital Council last year and is an increase of 722 beds over the number available Jan. 1, 1950.

Distribution of beds is as follows: 20,008 beds in 79 voluntary nonprofit hospitals; 9,711 beds in 17 municipal hospitals; 3,655 beds in 42 proprietary hospitals.

Award to Hospital

The Charles S. Wilson Memorial Hospital in Johnson City, N. Y., received an award for its food service installation in the fifth annual institutions food service contest.

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In the last two weeks of June 1951 these representative hospital campaigns came to highly satisfactory conclusions under BUREAU direction:

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West Coast Hospital Association

MARTINSVILLE, VIRGINIA
Martinsville General Hospital
Martinsville Community Hospital

NIAGARA FALLS, NEW YORK
Memorial Hospital

PASSAIC, NEW JERSEY
St. Mary's Hospital

PEKIN, ILLINOIS
Pekin Public Hospital

PORTSMOUTH, OHIO
Mercy Hospital

SACRAMENTO, CALIFORNIA
Mercy Hospital

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The award was based on efficiency, economic soundness, safety and sanitation of the service. Robert L. Eckelberger is administrator of the hospital.

Awards were presented at the National Restaurant Association convention in May in Chicago.

Seattle Children's Hospital

Ground-breaking ceremonies were held during May for the building of the new $5,000,000 Children's Orthopedic Hospital in Seattle. A 25-acre tract near the University of Washington Medical School is the site for the hospital. Architects' plans provide for 200 beds and space for 36 clinics, laboratories, x-ray and therapy rooms.

PROPOSED CHILDREN'S HOSPITAL

Established in 1907, Children's Orthopedic Hospital has grown into a general children's hospital with numerous specialized clinics. Lilian M. Thompson, R.N., is superintendent.

Bronx Medical Unit

Yeshiva University and the Bronx have united their plans for a hospital and medical center in the Bronx to form a $61,500,000 institution.

The city is spending $36,500,000 for a 500-bed tuberculosis hospital, to be completed next June, and a 750-bed general hospital, to be called the Bronx Municipal General Hospital. The facilities of the Municipal Hospital Center, now under construction, will be available to the university for the projected medical school.

The university will construct its $25,000,000 medical center adjacent to the Bronx hospital. The first building will be a $10,000,000 medical school.

Record Enrollment

A record enrollment of 72,176 persons for April was reported by Dr. Charles Gordon Heyd, president of the United Medical Service, New York's Blue Shield plan. The enrollment, the highest for any one month, brings the over-all membership to 2,145,117.

CURRENT LISTING OF NEW ASSOCIATION MEMBERS

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Troy—Beard Memorial Hospital, Inc.

ARIZONA

Phoenix—Desert Mission Convalescent Hospital

ARKANSAS

Malvern—Hot Springs County Memorial Hospital
Mena—Polk County Memorial Hospital
Rogers—Rogers Memorial Hospital

CALIFORNIA

Arcata—Trinity Hospital of Arcata

GEORGIA

McRae—McRae-Telfair County Hospital
Richland—Stewart-Webster Hospital

ILLINOIS

Anna—Anna City Hospital
Chicago—LaRabida Jackson Park Sanitarium
Galesburg—Galesburg State Research Hospital
Hazelcrest—Hazelcrest General Hospital

INDIANA

LaGrange—LaGrange County Hospital

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KENTUCKY

Covington—Covington-Kenton County Tuberculosis Sanatorium
Frankfort—State Tuberculosis Hospital Commission
Mount Sterling—Mary Chiles Hospital
Pineville—Pineville Community Hospital
Stanford—Stanford Hospital

LOUISIANA

Lake Charles—Southwest Louisiana Hospital Association, Inc.

MASSACHUSETTS

Athol—Athol Memorial Hospital
Springfield—Springfield Municipal Hospital
Whitinsville—The Whitinsville Hospital, Inc.

MICHIGAN

Detroit—Mercy General Hospital
Gaylord—Otsego County Memorial Hospital Association
Marlette—Marlette Community Hospital

MINNESOTA

Karlstad—Karlstad Memorial Hospital
Lakefield—Lakefield Municipal Hospital

MONTANA

Butte—Butte Community Memorial Hospital

NEBRASKA

Crawford—Community Memorial Hospital
Kimball—Kimball County Hospital

NEVADA

Carson City—Carson-Tahoe Hospital

NEW HAMPSHIRE

Concord—Bureau of Hospital Services, New Hampshire State Department of Health
East Derry—Alexander-Eastman Hospital

NEW YORK

Buffalo—The University of Buffalo Chronic Disease Research Institute
Great Neck, L.I.—North Shore Hospital Fund, Inc.
New York—The Long Island Jewish Hospital
Peekskill—The Peekskill Hospital

NORTH CAROLINA

Jamestown—Guilford County Sanatorium

OHIO

Bowling Green—Wood County Hospital Association
Columbus—Ohio Tuberculosis Hospital
Mount Gilead—Morrow County Hospital
Wilmington—The Clinton Memorial Hospital

OKLAHOMA

Holdenville—Physicians and Surgeons Hospital
Lawton—Comanche County Memorial Hospital

SOUTH CAROLINA

Bishopville—Lee County Memorial Hospital
Manning—Clarendon Memorial Hospital

SOUTH DAKOTA

Wessington Springs—Memorial Hospital

TENNESSEE

Cookeville—Cookeville General Hospital

TEXAS

Big Lake—Reagan County Memorial Hospital
Bryan—St. Joseph Hospital
Henrietta—Clay County Memorial Hospital
Yorktown—Yorktown Memorial Hospital

VIRGINIA

Pearisburg—Giles Memorial Hospital, Inc.
Rocky Mount—Franklin Memorial Hospital, Inc.

WEST VIRGINIA

Fairmont—Marion County Hospital Service, Inc. (Blue Cross)

WISCONSIN

Janesville—Pinehurst Sanatorium

WYOMING

Newcastle—Weston County Memorial Hospital
Torrington—Goshen County Memorial Hospital

CANADA

Toronto, Ont.—Department of Hospital Administration, School of Hygiene, University of Toronto
Ste. Agathe Des Monts, Que.—Mount Sinai Sanatorium

ISRAEL

Tel Aviv—Ministry of Defense Medical Department

PERSONAL

Adams, Robert E.—Asst. to Admin.—Research Hospital—Kansas City, Missouri
Arnall, William K.—Senior Med. Admin. Specl.—137th Medical Group—Alexandria (La.) Municipal Airport.
Atkins, Kenneth K.—Admin.—Bethesda Hospital—Crookston, Minn.
Beaudro, Lea G.—Asst. Admin.—Fort Hamilton (Ohio) Hospital
Boulenger, Albert L.—Student, Hosp. Admin.—Washington University—St. Louis
Cherkas, Marshall S.—Admin. Res.—Mount Sinai Hospital—Miami Beach, Fla.
Collins Francena L.—Diet. & Housekeeper—Anna Jaques Hospital—Newburyport, Mass.
Coressel, S. Germaine — Supt. — Toledo (Ohio) Society for Crippled Children
Cramer, Ambrose C.—Dir., Asst. Exec. to Pres.—Camden (Me.) Community Hospital
Dow, Eleanor R.—Chief Diet.—Salem (Mass.) Hospital
Fowler, Ralph W., M.D.—Trustee—Kennestone Hospital—Marietta, Ga.
Grapski, Ladislaus, F.—Asst. Dir.—Charge of Admin. Servs.—Johns Hopkins Hospital—Baltimore
Hoche, Herman E., Lt. (j.g.) MSC.—Admin. Res.—U. S. Naval Hospital—Philadelphia
Howard, C. C., M.D.—Med. Dir. —Clinic Hospital—Glasgow, Ky.
LeBard, Waverly E.—Med. Sup. Off.—Station Hospital, Miho AF Base—452 Med. Gp. APO 950 c/o PM—San Francisco
Luther, Oscar D.—Student, Hosp. Admin.—Northwestern University—Chicago
Macuen, Hester E.—Asst. Admin.—Robert Breck Brigham Hospital—Boston.
Mattix, George I.—Admin. Officer—Public Health Service, Supply Branch—U. S. Marine Hospital—Baltimore
McCann, W. Webster—Auditor—New England Deaconess Hospital—Boston

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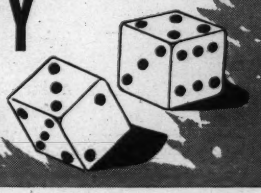

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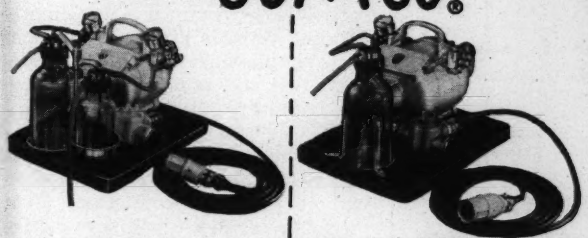

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*"*Fire Hazards in 171 Missouri Hospitals", by Roy Hudenburg, National Fire Protection Association Quarterly, April 1951.*

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